

1491 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Balto.		MARYLAND		STATE Md.		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Lutherville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS College Manor Nursing Ho.				STREET ADDRESS (If rural give location) Northway Apts.			
3. NAME OF DECEASED: (First) MAUDE (Middle) WILSON (Last) ADAMS				4. DATE (Month) (Day) (Year) OF DEATH: Feb. 14, 1956			
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) widowed	8. DATE OF BIRTH: Nov. 21, 1871	9. AGE last birthday 84 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ?		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Missouri		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: George Williams				14. MOTHER'S MAIDEN NAME: Harriette Hancock			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: Mrs. Alberta W. Lenzen-Northway Apts.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Arterio-sclerotic Heart Disease						5 yrs.	
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Cerebral arterio-sclerosis						2 years	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0 None		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from JUNE, 1951 , to Feb. 14, 1956 that I last saw the deceased alive on Dec. 15, 1955 , and that death occurred at 11:00 AM , from the causes and on the date stated above.							
SIGNATURE Crawford N. Kirkpatrick Jr.		M.D. 6 E. Eager St., Baltimore 2, Md.		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2/17/56		NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		LOCATION (City, town, or county) (State) Pikesville, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS 17	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

01361

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1402 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baito</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Baito</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Glenarm P.O.</u>		<u>25 yrs</u>		TOWN <u>Glenarm P.O.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Long Green md</u>				STREET ADDRESS (If rural give location) <u>Long Green md</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Eleanora Albrecht</u>				DEATH: <u>Feb 19 1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify): <u>Jan 31-1872</u>		8. DATE OF BIRTH:	
9. AGE last birthday <u>84 yrs.</u>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country): <u>Baito md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>At Home Housekeeper</u>				10B. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <u>Philip A Albrecht</u>				14. MOTHER'S MAIDEN NAME: <u>Eleanora Feyerman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY No. <u>NONE</u>			
17. INFORMANT & ADDRESS: <u>Mr Chas A Albrecht, Glenarm P.O.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Congestive Heart Failure</u>						<u>10 MOS.</u>	
ANTECEDENT CAUSE (B) <u>Arterio sclerotic Heart Dis.</u>						<u>2 yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg, etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>6/24</u> , 19 <u>55</u> to <u>2/19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/18</u> , 19 <u>56</u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Clifford F. Hudson</u> M.D.				ADDRESS <u>Fork, Md.</u>		DATE SIGNED <u>2/20/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/22/56</u>		<u>Baltimore Cen</u>		<u>Baito md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/22/56</u>		REGISTRAR'S SIGNATURE <u>Mrs. Hammett</u>		24. FUNERAL DIRECTOR		ADDRESS	
				<u>Larsen Funeral Home</u>		<u>7401 Belair Rd</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Clifford Hudson
Fork Rd.



BUREAU V. S.

MAR 7 1956

RECEIVED

01362

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1403 CERTIFICATE OF DEATH

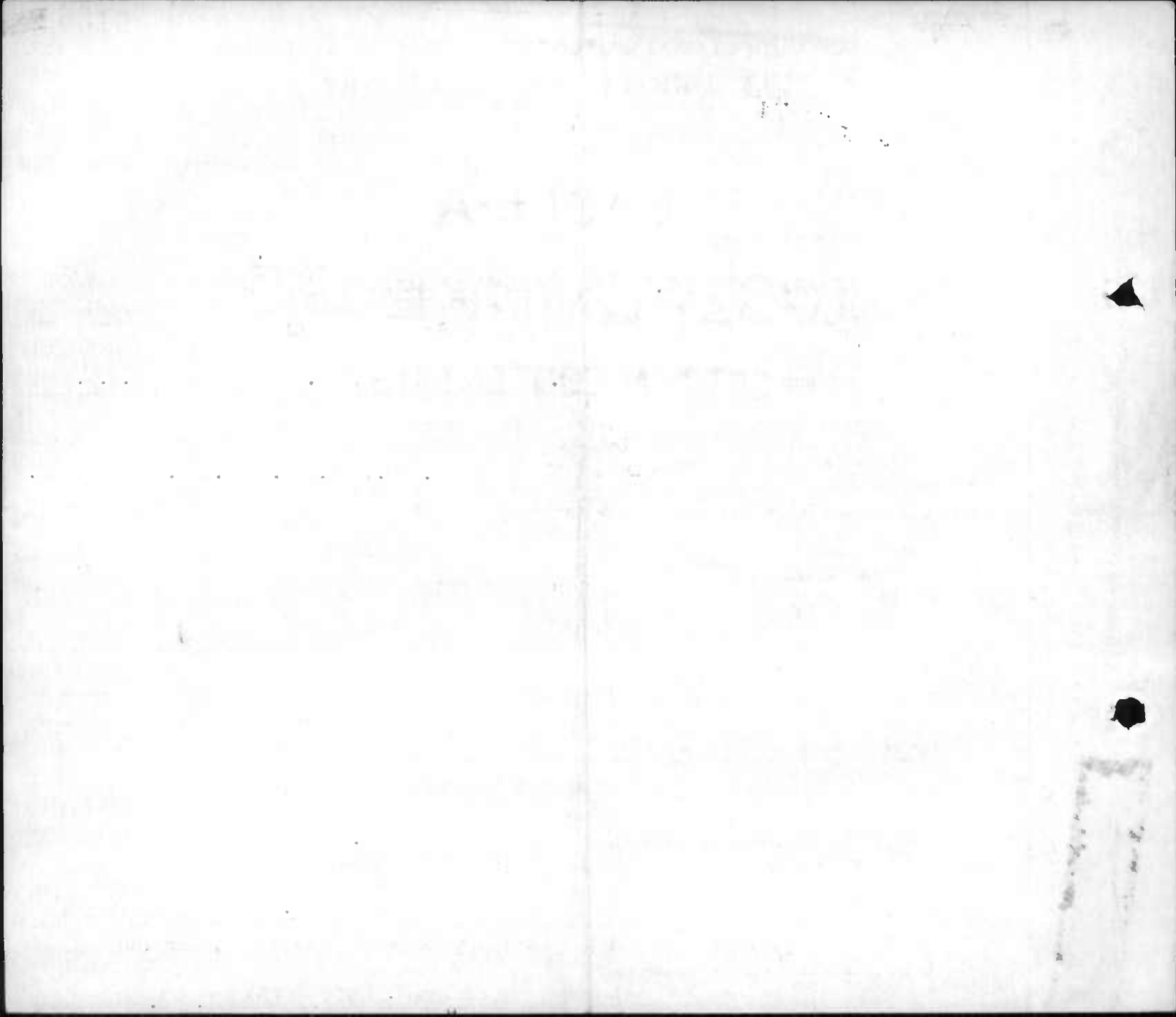
Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Baltimore</u>		<u>24 days</u>		OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1800 Etting Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>WILLIAM B. ALLEN</u>				<u>February 4, 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Negro</u>	<u>Widowed</u>	<u>12/11/01</u>	<u>54 yrs.</u>	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Chauffeur</u>		<u>Trucking Co.</u>		<u>Millwood, Va.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William Allen</u>				<u>Laura Bray</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:			
<u>Yes</u> <u>WW I</u>		<u>215-12-8855</u>		<u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						RECENT	
581.1 IMMEDIATE CAUSE (A) <u>HEPATIC COMA</u>							
ANTECEDENT CAUSE (B) <u>LAENNEC'S CIRRHOSIS</u>						UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 12, 1956</u> , to <u>Feb. 4, 1956</u> , that I last saw the deceased <u>alive on XXXXXXXXXX</u> and that death occurred at <u>9:40A M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>John A. Surmonte</u>		M. D. <u>Fort Howard, Md.</u>		DATE SIGNED <u>2/4/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/8/56</u>		<u>Baltimore National Cemetery</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Feb 6, 1956</u>		<u>A. W. Hedrick</u>		<u>Charles R. Law Funeral Home</u>		<u>802 Madison Ave., Baltimore 1, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 -- 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 70M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01363

1494

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Md.</u>		COUNTY <u>Balto.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Owens</u>		LENGTH OF STAY (In this place) <u>25 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>11 Cliftwood Rd</u>				STREET ADDRESS (If rural give location) <u>11 Cliftwood Rd</u>			
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>Wesley</u> (Middle) <u>Amoss</u> (Last)				4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>4</u> (Year) <u>19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>9-19-78</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hickster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Produce</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown Amoss</u>				14. MOTHER'S MAIDEN NAME <u>Unknown Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>213302468</u>		17. INFORMANT & ADDRESS <u>Daughter, 11 Cliftwood Rd</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
332X IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cerebral arteriosclerosis</u>						<u>5 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
		2D. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 31, 19 56</u>, to <u>Feb. 4, 19 56</u>, that I last saw the deceased alive on <u>Jan. 31, 19 56</u>, and that death occurred at <u>3 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>R. Ronald Jandoy</u>		DATE THEREOF <u>Feb. 8, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City, town, or county) <u>Balto, Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 8, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City, town, or county) <u>Balto, Md.</u>	
24. REC'D BY REGISTRAR <u>FEB 9 1956</u>		REGISTRAR'S SIGNATURE <u>Mrs. L. L. Reifsnieder</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home - 7401 Belair Rd.</u>		ADDRESS <u>7401 Belair Rd.</u>	

01308

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 19

CERTIFICATE OF DEATH

DATE OF DEATH

A. LEGAL REQUIREMENTS (FILL IN OR CHECK)

NAME OF DECEASED
DATE OF BIRTH
PLACE OF BIRTH
MARRIAGE
OCCUPATION
CAUSE OF DEATH
PLACE OF DEATH
DATE OF DEATH

MARYLAND

DATE OF BIRTH

PLACE OF BIRTH

MARRIAGE

OCCUPATION

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

B. STATE OF DEATH

NAME OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

MARRIAGE

OCCUPATION

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

IX. MEDICAL CERTIFICATION

BUREAU V. 2

FEB 10 1936

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RECEIVED

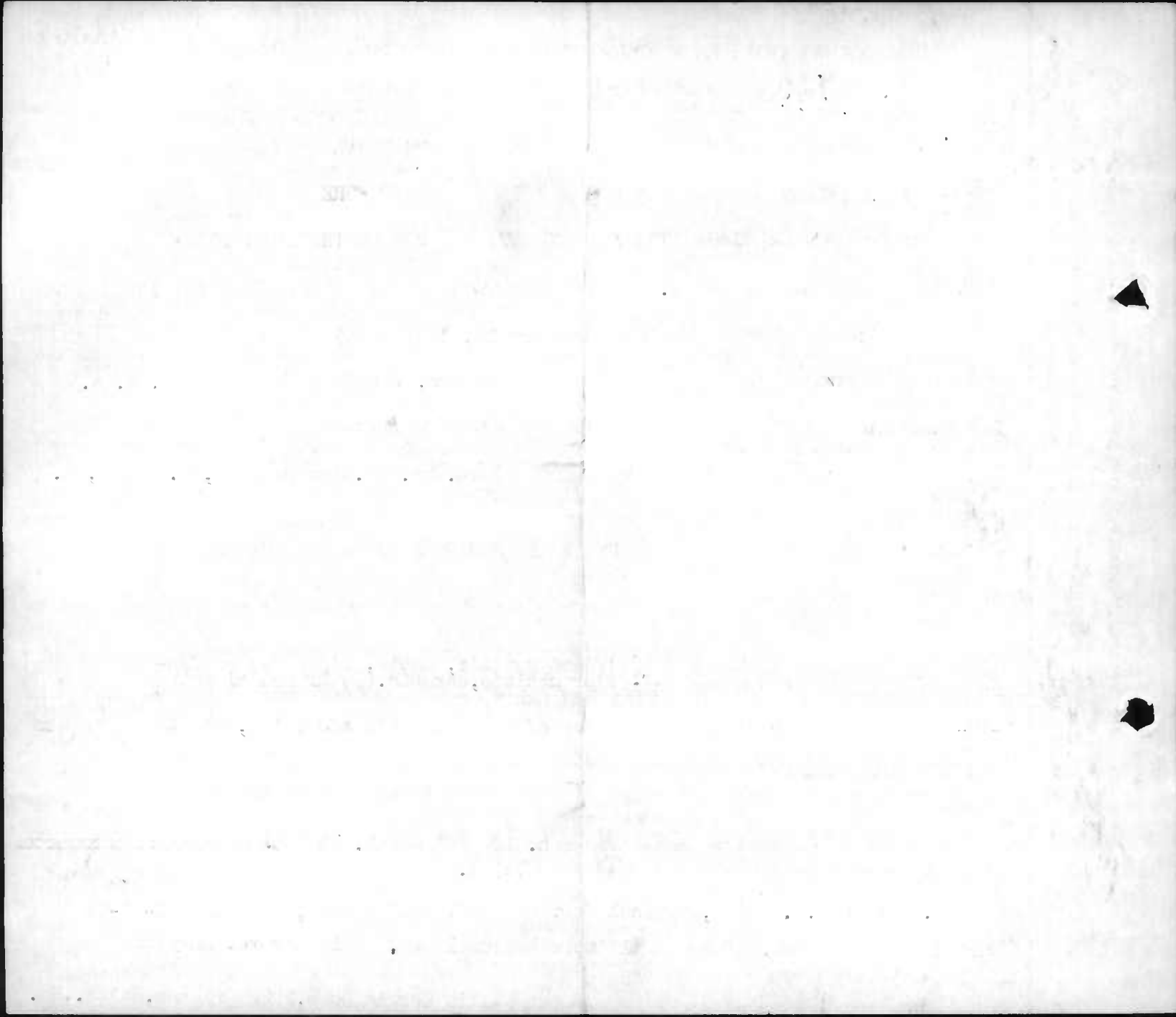
1405 CERTIFICATE OF DEATH

Reg. Dist. No. 44

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE	
TOWN FORT HOWARD	3 Days		
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) 206 NORTH CHAPEL STREET	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH	
LEMUEL T. ANDERTON		FEBRUARY 13 19 56	
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify):	8. DATE OF BIRTH:
Male	White	Married	January 29, 1897
9. AGE last birthday		10. AGE last birthday	
59 yrs.		59 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Sanford, Virginia		U. S. A.	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Lee Anderton		Caroline Andrews	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Yes WW I		Unknown	
17. INFORMANT & ADDRESS:			
Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) ACUTE BRAIN SYNDROME OF UNKNOWN CAUSE			UNKNOWN
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH			
(1) Tenosynovitis, acute, right second finger. (2) Bronchitis, chronic. (3) Bronchial asthma			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
2-10-56		Incision and drainage of tenosynovitis and felon, right	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 10, 1956, to Feb. 13, 1956 , and that death occurred at 7:35 A.M. , from the causes and on the date stated above.			
SIGNATURE Joseph M. Miller		ADDRESS VAH, FORT HOWARD, MARYLAND	
DATE SIGNED 2-13-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Burial		Feb. 16/56	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Baltimore National Cem.		Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
Philip Herwig Sons, 2024 Orleans, Balto., Md.			

MARGIN RESERVED FOR BINDING



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01365

1406

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hereford</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hereford</u>	
TOWN <u>Hereford</u>		LENGTH OF STAY (in this place) <u>50 yrs</u>		STREET ADDRESS (If rural give location) <u>York Rd.</u>		TOWN <u>Hereford</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>York Rd.</u>				STREET ADDRESS <u>York Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>Harry Scott Armacost</u>				4. DATE OF DEATH (Month) <u>Febr.</u> (Day) <u>23</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Jan. 6, 1888</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>State Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		9. AGE last birthday <u>68</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>Parkton, Md. R.D. 2, S. A.</u>	
13. FATHER'S NAME <u>Joshua Armacost</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>213-28-1752</u>		14. MOTHER'S MAIDEN NAME <u>Lida Miller</u>	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Arterio Sclerosis Cerebralis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) _____		21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____ M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <u>June 1953</u> , to <u>Feb. 23, 1956</u> , that I last saw the deceased alive on <u>Feb. 22, 1956</u> , and that death occurred at <u>6:35 A.</u> from the causes and on the date stated above.							
SIGNATURE <u>William B. Butler</u>				ADDRESS (Street, city, town, state) <u>White Hall Md.</u> DATE SIGNED <u>Feb. 25, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Febr. 26, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Fosters Cemetery</u>		LOCATION (City, town, or county) <u>Hereford</u> (State) <u>Md. R.D.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Charles J. Feltton</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		ADDRESS <u>New Freedom, B.</u>	
DATE <u>2/26/56</u>							

BUREAU V. S.

MAR 6 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC-123-10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01366

1497 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>TOWSON</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7906 KNOLLWOOD RD.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTO.</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>TOWSON</u> STREET ADDRESS (If rural give location) <u>7906 KNOLLWOOD RD.</u>	
3. NAME OF DECEASED (Type or Print) <u>GEORGE ANDREW DAETZ</u> (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>2-9-56</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1-27-1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ENGINEER ART. BLDGS.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO. MD.</u>	9. AGE last birthday <u>67</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>JOHN DAETZ</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET STECKER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-05-0139</u>	
17. INFORMANT & ADDRESS <u>HELEN M. DAETZ - SAME</u>			
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>153X IMMEDIATE CAUSE (A) Carcinomatosis</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Ca. of Colon</u>			INTERVAL BETWEEN ONSET AND DEATH
19. DATE OF OPERATION <u>1/24/56</u>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
19b. MAJOR FINDINGS OF OPERATION <u>advanced Ca of Colon</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>November 1953</u> , to <u>2/9/1956</u> , that I last saw the deceased alive on <u>2/9/1956</u> , and that death occurred at <u>7:05 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>M. X. Quinn, M.D.</u> ADDRESS (Street, city, town, state) <u>TIMONIUM MD 21156</u> DATE SIGNED <u>2/11/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2/13/56</u>	
NAME OF CEMETERY OR CREMATORY <u>SACRED HEART OF JESUS</u>		LOCATION (City, town, or county) (State) <u>BALTO CO. MD.</u>	
24. REC'D BY REGISTRAR DATE <u>FEB 14 1956</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Jenkins</u> ADDRESS <u>4905 YORK RD.</u>	

CERTIFICATE OF DEATH

Reg. Cert. No.

DEATH REPORTED UNDER NO. REGISTERED

DATE OF DEATH

TIME

PLACE

CAUSE OF DEATH

AGE

SEX

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME

PLACE

CAUSE OF DEATH

AGE

SEX

EDUCATION

RELIGION

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PLACE

CAUSE OF DEATH

AGE

SEX

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

BUREAU V. S.

FEB 14 1956

RECEIVED

1498

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland COUNTY City			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Owings Mills		4 yrs. 10 mos.		TOWN Baltimore 31, Maryland		3101-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rosewood St. Tr. School				STREET ADDRESS (If rural give location) 1740 East Baltimore Street			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)					
Linda Jean Baird		February 22, 1956					
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
female	white	single	2/21/49	7 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				Maryland		U. S.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
William Lloyd Baird				Joan Winifred Rinehart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
				Rosewood Records			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
492X							
IMMEDIATE CAUSE (A) Bilateral interstitial pneumonia						Several days	
DUE TO							
ANTECEDENT CAUSE (B) Repeated aspiration of food.							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Brain scars + internal hydrocephalus due to old							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
2		tubercular meningitis					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from , 19 , to , 19 , that I last saw the deceased alive on 2/22 , 19 56 , and that death occurred at 6:15 p.m. from the causes and on the date stated above.							
SIGNATURE Ruth G. Gindberg (Pathologist)				ADDRESS 700 Fleet Street Baltimore Md.		DATE SIGNED 2/23/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Removal		2/25/56		Edgemoor Cmt		West Monticoke, Pa	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
2-24-56				Wm J. Dornan		1740 East Baltimore Street	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

COMMONS
JAN 11 1964

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1499

CERTIFICATE OF DEATH

01368

Reg. Dist. No. 3

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore		TOWN 3Y01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS House in Pines 16 Rusting Ave.				STREET ADDRESS (If rural give location) 5005 Woodside Rd.			
3. NAME OF DECEASED (Type or Print) Fannie Beaumont				4. DATE OF DEATH (Month) (Day) (Year) Feb. 6/56			
5. SEX Female		6. COLOR OR RACE W.		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow		8. DATE OF BIRTH Sept. 4, 1872	
				9. AGE last birthday 83 yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) H.W.		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John William Buckingham				14. MOTHER'S MAIDEN NAME Janet Peacock			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS (Daughter) Mrs. J. Fred Graves, 5005 Woodside Rd.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) Myocardial Decomensation						INTERVAL BETWEEN ONSET AND DEATH 1 wk.	
ANTECEDENT CAUSE(S) DUE TO (B) Chronic Cardio-Vascular-Renal Disease						6 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9:14, 1949, to 2:56, 1956, that I last saw the deceased alive on 8-5, 1956, and that death occurred at 9:30 AM, from the causes and on the date stated above.							
SIGNATURE <i>John F. Gallagher</i>				ADDRESS (Street, city, town, state) M. 6209 Frederick Rd., Balt. 28, Md.		DATE SIGNED 2/7/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 9/56		NAME OF CEMETERY OR CREMATORY Douglas Park		LOCATION (City, town, or county) Baltimore, Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>T. E. Harry</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Harry H. Witke</i>		ADDRESS 4101 Edmondson AVE	
DATE FEB 8 1956							

CERTIFICATE OF DEATH

0130

Case No. 12

1. DECEASED'S NAME (Print or Write)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF PHYSICIAN

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF CLERK

13. SIGNATURE OF JUDGE

14. SIGNATURE OF SHERIFF

15. SIGNATURE OF CORONER

16. SIGNATURE OF DISTRICT ATTORNEY

17. SIGNATURE OF COUNTY CLERK

18. SIGNATURE OF TOWNSHIP CLERK

19. SIGNATURE OF VILLAGE CLERK

20. SIGNATURE OF CITY CLERK

21. SIGNATURE OF STATE CLERK

22. SIGNATURE OF DEPARTMENT CLERK

23. SIGNATURE OF HEALTH COMMISSIONER

24. SIGNATURE OF ASSISTANT COMMISSIONER

25. SIGNATURE OF CHIEF CLERK

26. SIGNATURE OF DEPUTY CHIEF CLERK

27. SIGNATURE OF RECORDS CLERK

28. SIGNATURE OF STATISTICS CLERK

29. SIGNATURE OF INSPECTION CLERK

30. SIGNATURE OF LABORATORY CLERK

31. SIGNATURE OF PHARMACY CLERK

32. SIGNATURE OF OPTICIAN CLERK

33. SIGNATURE OF DENTIST CLERK

34. SIGNATURE OF VETERINARY CLERK

35. SIGNATURE OF MIDWIFE CLERK

36. SIGNATURE OF NURSE CLERK

37. SIGNATURE OF HEALTH OFFICER

38. SIGNATURE OF SANITARY ENGINEER

39. SIGNATURE OF PUBLIC HEALTH NURSE

40. SIGNATURE OF HEALTH ASSISTANT

41. SIGNATURE OF HEALTH INSPECTOR

42. SIGNATURE OF HEALTH CLERK

43. SIGNATURE OF HEALTH OFFICER

44. SIGNATURE OF SANITARY ENGINEER

45. SIGNATURE OF PUBLIC HEALTH NURSE

46. SIGNATURE OF HEALTH ASSISTANT

47. SIGNATURE OF HEALTH INSPECTOR

48. SIGNATURE OF HEALTH CLERK

49. SIGNATURE OF HEALTH OFFICER

50. SIGNATURE OF SANITARY ENGINEER

51. SIGNATURE OF PUBLIC HEALTH NURSE

52. SIGNATURE OF HEALTH ASSISTANT

53. SIGNATURE OF HEALTH INSPECTOR

54. SIGNATURE OF HEALTH CLERK

55. SIGNATURE OF HEALTH OFFICER

56. SIGNATURE OF SANITARY ENGINEER

57. SIGNATURE OF PUBLIC HEALTH NURSE

58. SIGNATURE OF HEALTH ASSISTANT

59. SIGNATURE OF HEALTH INSPECTOR

60. SIGNATURE OF HEALTH CLERK

61. SIGNATURE OF HEALTH OFFICER

62. SIGNATURE OF SANITARY ENGINEER

63. SIGNATURE OF PUBLIC HEALTH NURSE

64. SIGNATURE OF HEALTH ASSISTANT

65. SIGNATURE OF HEALTH INSPECTOR

66. SIGNATURE OF HEALTH CLERK

67. SIGNATURE OF HEALTH OFFICER

68. SIGNATURE OF SANITARY ENGINEER

69. SIGNATURE OF PUBLIC HEALTH NURSE

70. SIGNATURE OF HEALTH ASSISTANT

71. SIGNATURE OF HEALTH INSPECTOR

72. SIGNATURE OF HEALTH CLERK

73. SIGNATURE OF HEALTH OFFICER

74. SIGNATURE OF SANITARY ENGINEER

75. SIGNATURE OF PUBLIC HEALTH NURSE

76. SIGNATURE OF HEALTH ASSISTANT

77. SIGNATURE OF HEALTH INSPECTOR

78. SIGNATURE OF HEALTH CLERK

79. SIGNATURE OF HEALTH OFFICER

80. SIGNATURE OF SANITARY ENGINEER

81. SIGNATURE OF PUBLIC HEALTH NURSE

82. SIGNATURE OF HEALTH ASSISTANT

83. SIGNATURE OF HEALTH INSPECTOR

84. SIGNATURE OF HEALTH CLERK

85. SIGNATURE OF HEALTH OFFICER

86. SIGNATURE OF SANITARY ENGINEER

87. SIGNATURE OF PUBLIC HEALTH NURSE

88. SIGNATURE OF HEALTH ASSISTANT

89. SIGNATURE OF HEALTH INSPECTOR

90. SIGNATURE OF HEALTH CLERK

91. SIGNATURE OF HEALTH OFFICER

92. SIGNATURE OF SANITARY ENGINEER

93. SIGNATURE OF PUBLIC HEALTH NURSE

94. SIGNATURE OF HEALTH ASSISTANT

95. SIGNATURE OF HEALTH INSPECTOR

96. SIGNATURE OF HEALTH CLERK

97. SIGNATURE OF HEALTH OFFICER

98. SIGNATURE OF SANITARY ENGINEER

99. SIGNATURE OF PUBLIC HEALTH NURSE

100. SIGNATURE OF HEALTH ASSISTANT

101. SIGNATURE OF HEALTH INSPECTOR

102. SIGNATURE OF HEALTH CLERK

103. SIGNATURE OF HEALTH OFFICER

104. SIGNATURE OF SANITARY ENGINEER

105. SIGNATURE OF PUBLIC HEALTH NURSE

106. SIGNATURE OF HEALTH ASSISTANT

107. SIGNATURE OF HEALTH INSPECTOR

108. SIGNATURE OF HEALTH CLERK

109. SIGNATURE OF HEALTH OFFICER

110. SIGNATURE OF SANITARY ENGINEER

111. SIGNATURE OF PUBLIC HEALTH NURSE

112. SIGNATURE OF HEALTH ASSISTANT

113. SIGNATURE OF HEALTH INSPECTOR

114. SIGNATURE OF HEALTH CLERK

115. SIGNATURE OF HEALTH OFFICER

116. SIGNATURE OF SANITARY ENGINEER

117. SIGNATURE OF PUBLIC HEALTH NURSE

118. SIGNATURE OF HEALTH ASSISTANT

119. SIGNATURE OF HEALTH INSPECTOR

120. SIGNATURE OF HEALTH CLERK

121. SIGNATURE OF HEALTH OFFICER

122. SIGNATURE OF SANITARY ENGINEER

123. SIGNATURE OF PUBLIC HEALTH NURSE

124. SIGNATURE OF HEALTH ASSISTANT

125. SIGNATURE OF HEALTH INSPECTOR

126. SIGNATURE OF HEALTH CLERK

RECEIVED

BUREAU V. S.

FEB 5 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Medical Examiners Certificate
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **01369**
1410 **CERTIFICATE OF DEATH** **Reg. Dist. No. 43**

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Md.	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Raspeburg	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Raspeburg	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7936 Oakdale Avenue		STREET ADDRESS (If rural give location) 7936 Oakdale Avenue	
3. NAME OF DECEASED: (First) (Middle) (Last) MARY L. BECKER		4. DATE (Month) (Day) (Year) OF DEATH: February 23, 19 56	
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: Feb. 22, 1898
9. AGE last birthday: 58 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework		10B. KIND OF BUSINESS OR INDUSTRY: At Home	
11. BIRTHPLACE (State or foreign country): Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Henry Becker		14. MOTHER'S MAIDEN NAME: M. W. Gramder	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT & ADDRESS: Mr. Henry Becker, 7936 Oakdale Ave., Balto. 6			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
581.0 IMMEDIATE CAUSE (A) Pulmonary Embolus			1 hour
ANTECEDENT CAUSE (B) Arteriosclerosis of heart			2 yrs.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2-23-56 , to 19 , that I last saw the deceased alive on 19 , and that death occurred at 10:30 M, from the causes and on the date stated above.			
SIGNATURE Jack C. Ballus		DATE SIGNED 2-27-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		24. FUNERAL DIRECTOR ADDRESS	
DATE THEREOF 2/25/56		LOCATION (City, town, or county) (State) Baltimore, Maryland	
NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery			
DATE REC'D BY LOCAL REGISTRAR Feb. 24 '56		REGISTRAR'S SIGNATURE Mrs. M. R. Kufner	
25. FUNERAL HOME ADDRESS 7401 Belair Rd.			

BUREAU V. S.

FEB 29 1956

RECEIVED

1411

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH: Rosewood St. Tr. School

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X TOWN Owings Mills, Md.

LENGTH OF STAY (in this place)

1 1/2 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

12 Rosewood State Tr. Shhool

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY City

CITY (If outside corporate limits, write RURAL and give nearest town) OR

TOWN Baltimore 15, Maryland 3V01-4

STREET ADDRESS (If rural give location)

4505 Post Road

3. NAME OF DECEASED: (Type or Print)

(First)

(Middle)

(Last)

Frederick

PETER

Behm

4. DATE (Month) OF DEATH: 2/29/

(Day)

(Year)

19 56

5. SEX:

male

6. COLOR OR RACE:

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

single

8. DATE OF BIRTH:

11/1/13

9. AGE last birthday 42 yrs.

10. IF UNDER 1 YEAR Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

NONE

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Peter George Behm

14. MOTHER'S MAIDEN NAME:

Meta Elizabeth Susemihl-Behm

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

NO

16. SOCIAL SECURITY NO.

NONE

17. INFORMANT & ADDRESS:

Rosewood Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

490X

IMMEDIATE CAUSE

(A) Pulmonary Edema

DUE TO

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) Bilateral Pneumonia

DUE TO

(C) Mongoloid, idiot

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/1, 19 54 to 2/29, 1956, that I last saw the deceased

alive on 2/29, 19 56, and that death occurred at 11:00aM, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

M.D.

2920 N. CALVEAT ST. 2-29-56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

BURIAL

NAME OF CEMETERY OR CREMATORY

MARCH 2, 1956

LOUDON PARK CEM.

LOCATION (City, town, or county)

BALTIMORE MD.

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

HENRY SANDER & SONS INC.

ADDRESS

BALTIMORE MD.

Sander & Sander

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

COMPTON
AVIATION

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

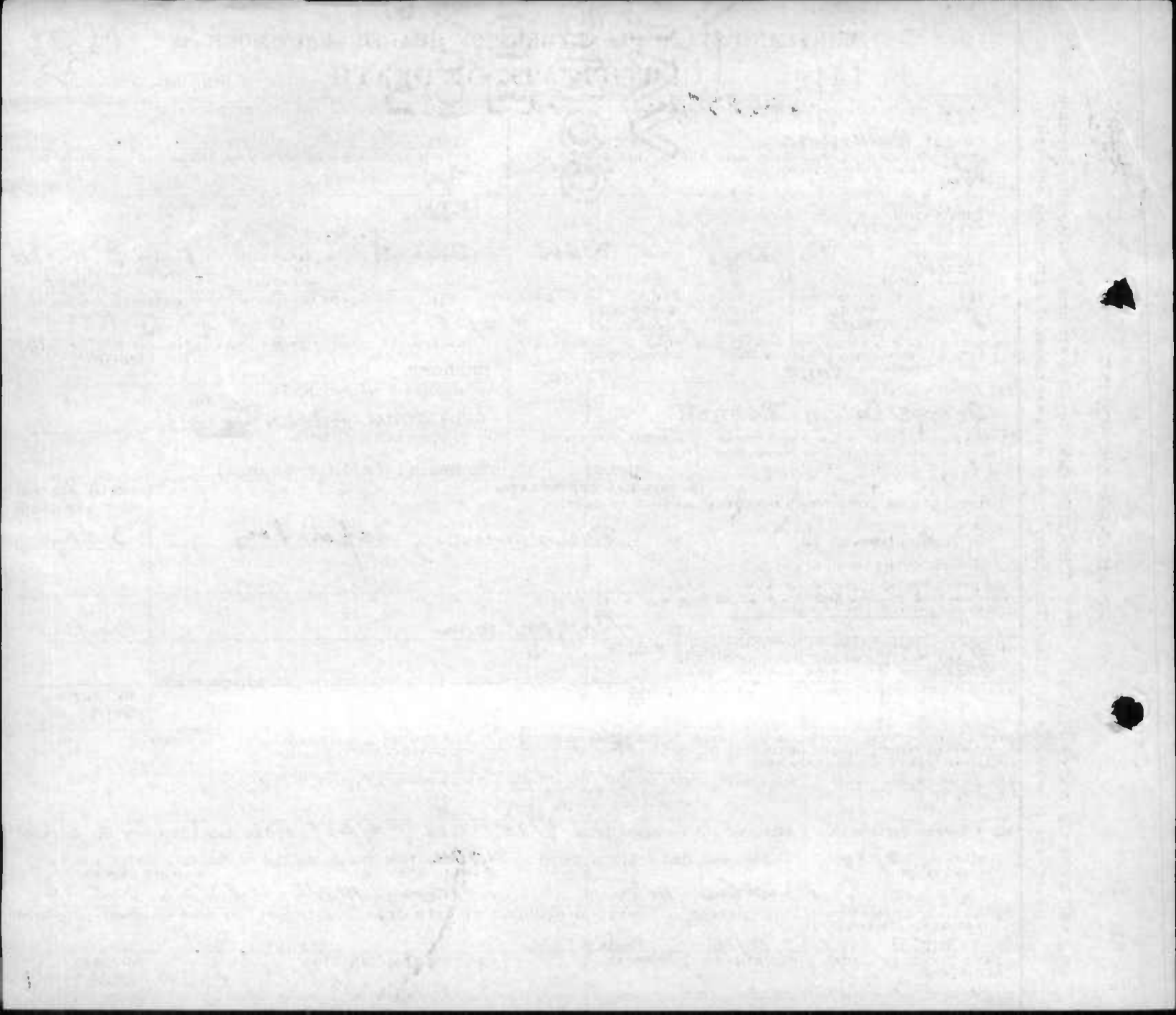
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01371

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH: <i>Rosewood Training School</i>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Pri. Geo.</i>
CITY (if outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (if outside corporate limits, write RURAL and give nearest town)	
X TOWN		TOWN <i>Suitland</i>	<i>16X-2</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>12</i>		STREET ADDRESS (If rural give location) <i>P. O. Box 9132</i>	
3. NAME OF DECEASED: (First <i>George</i> (Middle <i>Dean</i> (Last <i>Bennett</i>).		4. DATE (Month <i>5</i> (Day <i>5</i> (Year <i>1956</i>)	
5. SEX: <i>Male</i>		6. DATE OF DEATH: <i>2-25-56</i>	
7. COLOR OR RACE: <i>white</i>	8. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>single</i>	9. AGE last birthday <i>5</i> yrs.	IF UNDER 1 YEAR: Months <i>9</i> Days <i>22</i> Hours <i></i> Min. <i></i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>None</i>	10B. KIND OF BUSINESS OR INDUSTRY: <i>None</i>	11. BIRTHPLACE (State or foreign country): <i>unknown</i>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <i>George Calvin Bennett</i>		14. MOTHER'S MAIDEN NAME: <i>Larocca Aileen Terwell.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>none</i>	
		17. INFORMANT & ADDRESS: <i>Rosewood Training School</i>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Pneumonia, asperatory</i>			<i>3 days</i>
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <i>Gargoylism</i>			<i>Birth</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>7/10</i> , 1953, to <i>2/25</i> , 1956, that I last saw the deceased alive on <i>2/24</i> , 1956, and that death occurred at <i>8:30 AM</i> from the causes and on the date stated above.			
SIGNATURE <i>Sam B. Butler M.D.</i>		DATE SIGNED <i>25 Feb 56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2/28/56</i>	NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>
DATE REC'D BY LOCAL REGISTRAR <i>2-27-56</i>		LOCATION (City, town, or county) (State) <i>Sitland, Md.</i>	
REGISTRAR'S SIGNATURE <i>L</i>		24. FUNERAL DIRECTOR ADDRESS <i>Wm. J. Lickner & Sons - Balt. 17th</i>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01372

1413 **CERTIFICATE OF DEATH**

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Reisterstown				TOWN Reisterstown			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Cockeysmill Road				STREET ADDRESS (If rural give location) Cockeysmill Road			
3. NAME OF DECEASED (Type or Print) Charles F. Bertsch				4. DATE OF DEATH (Month) (Day) (Year) Feb. 10, 1956			
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH May, 26, 1877	
				9. AGE last birthday 78 yrs.		IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Self Employed				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Germany	
13. FATHER'S NAME Jacob Bertsch				14. MOTHER'S MAIDEN NAME Sophie Hagar			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Mr. Charles P. Bertsch, Reisterstown			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) 420.1 Coronary Thrombosis				INTERVAL BETWEEN ONSET AND DEATH Sudden			
ANTECEDENT CAUSE(S) DUE TO (B) Hypertension & general arteriosclerosis				Two years			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) Diabetes mellitus				few years			
19. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 1-1-56		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1-1-56, 1930, to 2-10-56, 1956, that I last saw the deceased alive on 1-1-56, 1956, and that death occurred at 3 A.M. from the causes and on the date stated above.							
SIGNATURE <i>James L. Safell</i>				DATE SIGNED 2-11-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 13, 1956		NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		LOCATION (City, town, or county) Baltimore, Co. Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Mary B. Eline</i>		25. FUNERAL DIRECTOR'S SIGNATURE J.F. Eline & Son's Reisterstown, Md.			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

Reg. Dist. No.

County and District where death occurred

City, Town or Village

State

Post Office

Residence

Occupation

Age

Sex

Color

Marital Status

Education

Religion

Cause of Death

Immediate Cause

Underlying Cause

Contributing Cause

Mode of Death

Place of Death

Time of Death

Date of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of County Clerk

Signature of State Registrar

Signature of Federal Registrar

Signature of National Registrar

Signature of International Registrar

Signature of World Registrar

Signature of Universal Registrar

Signature of Global Registrar

Signature of Cosmic Registrar

BUREAU V. S.

FEB 15 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01373

1414 CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE MD.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Catonsville				TOWN Baltimore		3V01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
House in Pines 16 Fusting Ave.				524 Edgewood St			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) Caroline (Middle) M. Biemiller (Last)				(Month) Feb. (Day) 6 (Year) 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	W.	Single	Aug. 21, 1868	87 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
None		None		Baltimore, Md.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Henry Biemiller				Caroline M. Preisz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				Mrs. Caleb Dorsey, 3513 Edmondson A			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) Coronary occlusion						2 min.	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE						3 yrs.	
STATING UNDERLYING CAUSE LAST, DUE TO							
(C) Arterio sclerosis						?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED V/hile <input type="checkbox"/> Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 19 52 , to Feb. 6 , 19 56 , that I last saw the deceased alive on Dec. 30 , 19 55 , and that death occurred at 4:30 P. from the causes and on the date stated above.							
SIGNATURE Walter D. Dille				ADDRESS (Street, city, town, state)		DATE SIGNED	
				M.D. 2220 Garrison Blvd.		2/7/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Feb. 9/56		Laudon Pl. Balto. Md.			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
FEB 9 1956		T. E. Hays		Harry H. Witzke		4101 Edmondson	

91213

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

1914 CERTIFICATE OF DEATH

Reg. Dist. No.

1. MARRIAGE NUMBER (NUMBER OF MARRIAGES)

2. PLACE OF BIRTH

MARRIAGE

CERTIFICATE

3. DATE OF BIRTH

4. PLACE OF BIRTH

5. DATE OF DEATH

6. CAUSE OF DEATH

7. PLACE OF DEATH

8. SEX

9. AGE

10. OCCUPATION

11. PLACE OF BIRTH

12. PLACE OF DEATH

13. DATE OF DEATH

14. PLACE OF DEATH

15. CAUSE OF DEATH

16. PLACE OF DEATH

17. DATE OF DEATH

18. SEX

19. AGE

20. OCCUPATION

21. PLACE OF BIRTH

22. PLACE OF DEATH

23. DATE OF DEATH

24. SEX

25. AGE

26. OCCUPATION

27. PLACE OF BIRTH

28. PLACE OF DEATH

29. DATE OF DEATH

30. SEX

31. AGE

32. OCCUPATION

33. PLACE OF BIRTH

34. PLACE OF DEATH

35. DATE OF DEATH

36. SEX

37. AGE

38. OCCUPATION

39. PLACE OF BIRTH

40. PLACE OF DEATH

41. DATE OF DEATH

42. SEX

43. AGE

44. OCCUPATION

45. PLACE OF BIRTH

46. PLACE OF DEATH

47. DATE OF DEATH

48. SEX

49. AGE

50. OCCUPATION

51. PLACE OF BIRTH

52. PLACE OF DEATH

53. DATE OF DEATH

54. SEX

55. AGE

56. OCCUPATION

57. PLACE OF BIRTH

58. PLACE OF DEATH

59. DATE OF DEATH

60. SEX

61. AGE

62. OCCUPATION

63. PLACE OF BIRTH

64. PLACE OF DEATH

65. DATE OF DEATH

66. SEX

67. AGE

68. OCCUPATION

69. PLACE OF BIRTH

70. PLACE OF DEATH

71. DATE OF DEATH

72. SEX

73. AGE

74. OCCUPATION

75. PLACE OF BIRTH

76. PLACE OF DEATH

77. DATE OF DEATH

78. SEX

79. AGE

80. OCCUPATION

81. PLACE OF BIRTH

82. PLACE OF DEATH

83. DATE OF DEATH

84. SEX

85. AGE

86. OCCUPATION

87. PLACE OF BIRTH

88. PLACE OF DEATH

89. DATE OF DEATH

90. SEX

91. AGE

92. OCCUPATION

93. PLACE OF BIRTH

94. PLACE OF DEATH

95. DATE OF DEATH

96. SEX

97. AGE

98. OCCUPATION

99. PLACE OF BIRTH

100. PLACE OF DEATH

101. DATE OF DEATH

102. SEX

103. AGE

104. OCCUPATION

105. PLACE OF BIRTH

106. PLACE OF DEATH

107. DATE OF DEATH

108. SEX

109. AGE

110. OCCUPATION

111. PLACE OF BIRTH

112. PLACE OF DEATH

113. DATE OF DEATH

114. SEX

115. AGE

116. OCCUPATION

117. PLACE OF BIRTH

118. PLACE OF DEATH

119. DATE OF DEATH

120. SEX

121. AGE

122. OCCUPATION

123. PLACE OF BIRTH

124. PLACE OF DEATH

125. DATE OF DEATH

126. SEX

127. AGE

128. OCCUPATION

129. PLACE OF BIRTH

130. PLACE OF DEATH

131. DATE OF DEATH

132. SEX

133. AGE

134. OCCUPATION

135. PLACE OF BIRTH

136. PLACE OF DEATH

137. DATE OF DEATH

138. SEX

139. AGE

140. OCCUPATION

141. PLACE OF BIRTH

142. PLACE OF DEATH

143. DATE OF DEATH

144. SEX

145. AGE

146. OCCUPATION

147. PLACE OF BIRTH

148. PLACE OF DEATH

149. DATE OF DEATH

150. SEX

151. AGE

152. OCCUPATION

153. PLACE OF BIRTH

154. PLACE OF DEATH

155. DATE OF DEATH

156. SEX

157. AGE

158. OCCUPATION

159. PLACE OF BIRTH

160. PLACE OF DEATH

161. DATE OF DEATH

162. SEX

163. AGE

164. OCCUPATION

165. PLACE OF BIRTH

166. PLACE OF DEATH

167. DATE OF DEATH

168. SEX

169. AGE

170. OCCUPATION

171. PLACE OF BIRTH

172. PLACE OF DEATH

173. DATE OF DEATH

174. SEX

175. AGE

176. OCCUPATION

177. PLACE OF BIRTH

178. PLACE OF DEATH

179. DATE OF DEATH

BUREAU V. 2

FEB 9 1956

RECEIVED

1415
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Catonsville</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>23X-1</i>
CITY (If outside corporate limits, write RURAL or and give nearest town) <i>52 Baltimore</i>	LENGTH OF STAY (in this place) <i>2 1/2 days</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>14 Spring Grove State Hospital</i>	STREET ADDRESS (If rural give location) <i>Del. House of Correction-Bredwell, Md.</i>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<i>Joseph Blitzman</i>		<i>2 16 1956</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>	8. DATE OF BIRTH: <i>5-24-1898</i>
9. AGE last birthday <i>57</i> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>-</i>	11. BIRTHPLACE (State or foreign country): <i>U.S.A. (Maryland)</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME: <i>Michael</i>	
14. MOTHER'S MAIDEN NAME: <i>Rebecca</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>unknown</i> (If Yes, give war or dates of service) <i>-</i>	
16. SOCIAL SECURITY NO. <i>unknown</i>		17. INFORMANT & ADDRESS: <i>Records Spring Grove State Hosp.</i>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <i>422.1 Cardio-vascular disease</i>			
ANTECEDENT CAUSE (B) <i>(Cerebral hemorrhagic?)</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>Dec. 7</i> , 1953, to <i>Feb. 16</i> , 1956, that I last saw the deceased alive on <i>Feb. 16</i> , 1956, and that death occurred at <i>6:50 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>L. Shyne Williams</i>		ADDRESS <i>M.D. Spring Grove State Hosp.</i> DATE SIGNED <i>2-16-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Embalmed</i>		DATE THEREOF <i>2/21/56</i>	
NAME OF CEMETERY OR CREMATORY <i>Univ. of Md. Med. School</i>		LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>FEB 27 1956</i>		REGISTRAR'S SIGNATURE <i>P. E. Harris</i>	
24. FUNERAL DIRECTOR		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

168cm,

131 lb

BUREAU V. S.

FEB 28 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01375

1416 **CERTIFICATE OF DEATH**

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Carroll</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>10 Days</u>		TOWN <u>New Windsor</u>		<u>06x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>WILLIAM</u>		(Middle) <u>P.</u>		(Last) <u>BLOOM, SR.</u>		<u>February 13</u> 19 <u>56</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>September 5, 1894</u>	<u>61</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Painter</u>		<u>Buildings</u>		<u>New Windsor, Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Adam Bloom</u>				<u>Mary Azealea</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u>		<u>WW 1</u>		<u>Unknown</u>			
				<u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>161X RESIDUAL CARCINOMA OF LARYNX WITH METASTASIS</u>						<u>Since</u>	
ANTECEDENT CAUSE(S) (B)						<u>TO LEFT BRACHIAL PLEXUS AND THE CERVICAL VERTEBRAE 1952</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>6-16-52</u>		<u>Laryngectomy - Squamous Carcinoma found</u>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
		<u>VA</u>					
22. I hereby certify that I attended the deceased from <u>Feb. 3, 1956</u>, to <u>Feb. 13, 1956</u>, and that death occurred at <u>5:00 P.</u> M., from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<u>D. D. MARK, M.D.</u>				<u>VAH, FORT HOWARD, MARYLAND</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>				<u>2-15-56</u>		<u>Presbyterian Cemetery</u>	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
<u>Feb. 16, 1956</u>				<u>Dawson L. Farley</u>		<u>Wm. Cook-Blight, Inc. 6009 Harford Rd., Balto.</u>	

DATE SIGNED

2-14-56

1418 CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18

BUREAU V. S.

FEB 17 1918

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01376

1390 CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> MARYLAND		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Viola</u>		STATE <u>Md</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Viola</u>	
TOWN <u>Viola</u>		LENGTH OF STAY (in this place) <u>10 yrs</u>		OR TOWN <u>Viola</u>		STREET ADDRESS (If rural give location) <u>3807 Coolidge Ave</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3807 Coolidge Ave</u>				STREET ADDRESS <u>3807 Coolidge Ave</u>			
3. NAME OF DECEASED: (First) <u>Alfred</u> (Middle) <u>Boffen</u> (Last) <u>Boffen</u>				4. DATE (Month) <u>Feb</u> (Day) <u>6</u> (Year) <u>1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Apr 29, 1872</u>	
9. AGE last birthday <u>83</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Mins.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Taylor</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Retired</u>		11. BIRTHPLACE (State or foreign country): <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>Naturalized U.S.A.</u>	
13. FATHER'S NAME: <u>Conrad Boffen</u>				14. MOTHER'S MAIDEN NAME: <u>Frances Wengarten</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY NO. <u>220-05-3620</u>		17. INFORMANT & ADDRESS: <u>Mrs Amelia Boffen Balto 29 Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>acute coronary occlusion</u>						<u>2d</u>	
ANTECEDENT CAUSE (B) <u>chronic myocarditis</u>						<u>5 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>General arteriosclerosis</u>						<u>5 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Semility</u>						<u>10 yrs</u>	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 5, 1956</u> , to <u>Feb 6, 1956</u> that I last saw the deceased alive on <u>Feb 6, 1956</u> , and that death occurred at <u>3:10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. B. B. Boffen</u>		ADDRESS <u>5608 Main St</u>		DATE SIGNED <u>4/6/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-9-56</u>		NAME OF CEMETERY OR CREMATORY <u>Gion</u>		LOCATION (City, town, or county) (State) <u>Howard Co Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/8/56</u>		REGISTRAR'S SIGNATURE <u>Dr. B. B. Boffen</u>		24. FUNERAL DIRECTOR <u>Howard St</u>		ADDRESS <u>4107 Wickers</u>	

BUREAU V. S.

FEB 10 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH: <u>Rosewood Training School</u>				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MIDDLE		STATE <u>Md</u>		COUNTY <u>Montgomery</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN <u>Gaboma Park</u> 15-17-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood St. Tr. School</u>				STREET ADDRESS (If rural give location)		<u>6606 Poplar Ave.</u>	
3. NAME OF DECEASED: (First) <u>Albert</u> (Middle) <u>Francis</u> (Last) <u>Bonifant</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb. 25, 1956</u>			
5. SEX: <u>M.</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>10/24/19</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday <u>36</u> yrs. <u>4</u> Months <u>1</u> Days		11. BIRTHPLACE (State or foreign country): <u>Gaboma Park, Md</u>	
13. FATHER'S NAME: <u>Thomas Bonifant</u>				14. MOTHER'S MAIDEN NAME: <u>Eve L. Gittings Bonifant</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Eve L. Bonifant 6606 Poplar Ave. Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Malignant tumor of chest.</u>							
ANTECEDENT CAUSE (B) <u>COMPRESSION OF TRACHEA AND HEART FAILURE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>DUE TO EXTENSIVE METASTASES OF SEMINOMA.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>11-7-55-</u>				19B. MAJOR FINDINGS OF OPERATION: <u>Seminoma RT Testicle.</u>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>M.</u>				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov 2, 1955</u> , to <u>Feb 25, 1956</u> , that I last saw the deceased alive on <u>2/25/</u> , 1956, and that death occurred at <u>9:00 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>John J. Arnold</u>				ADDRESS <u>1 M.D. 2920 N. Calvert St</u>		DATE SIGNED <u>2/26/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF: <u>Feb 28, 1956</u>		NAME OF CEMETERY OR CREMATORY: <u>George Washington Em</u>		LOCATION (City, town, or county) (State): <u>Reggs Rd. Pr. Geo. Md</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>2-27-56</u>		REGISTRAR'S SIGNATURE: <u>Mary B. Eline</u>		24. FUNERAL DIRECTOR: <u>John L. Walters</u>		ADDRESS: <u>254 Carroll St NW</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 5 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1418

CERTIFICATE OF DEATH

01378

Item 14, Film G193 2-23-56 et

Reg. Dist. No. 40

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Kingsville				TOWN Kingsville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Belair Rd. & Cherrol Road				STREET ADDRESS (If rural give location) Belair Road & Cherrol Road			
3. NAME OF DECEASED (Type or Print) Elizabeth (First) (Middle) (Last) Bose				4. DATE OF DEATH (Month) (Day) (Year) Feb. 15 1956			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH Nov. 3, 1868		9. AGE last birthday 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Kniesche				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Kingsville, Md. Mrs. Margaret Gonnson, Belair & Cherrol			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A) Coronary occlusion ANTECEDENT CAUSE(S) DUE TO (B) Generalized Arteriosclerosis DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)						INTERVAL BETWEEN ONSET AND DEATH 45 min. 20+ yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 1954, to Feb. 15, 1956, that I last saw the deceased alive on Feb. 15, 1956, and that death occurred at 10:45 A.M. from the causes and on the date stated above. SIGNATURE William A. Tyson M.D. ADDRESS (Street, city, town, state) Kingsville, Md. Feb. 15, 1956 DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 18, 1956		NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. REC'D BY REGISTRAR FEB 17 1956		REGISTRAR'S SIGNATURE Mrs. G. L. Ruffenberger		25. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road #14			

1-118

CERTIFICATE OF DEATH

Reg. No. 1-118

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. RACE

5. DATE OF BIRTH

6. PLACE OF BIRTH

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. NAME OF PHYSICIAN	12. NAME OF HOSPITAL	13. NAME OF NURSE
14. NAME OF MINISTER	15. NAME OF CHURCH	16. NAME OF FUNERAL HOME
17. NAME OF BURIAL PLACE	18. NAME OF CEMETERY	19. NAME OF INTERMENT

20. NAME OF CORONER	21. NAME OF JURY	22. NAME OF JUDGE
23. NAME OF SHERIFF	24. NAME OF CLERK	25. NAME OF RECORDS
26. NAME OF DEPUTY	27. NAME OF ASSISTANT	28. NAME OF ATTORNEY

BUREAU V. S.

FEB 17 1956

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.
VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01379

1419 **CERTIFICATE OF DEATH**

Reg. Dist. No. 45

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL or end give nearest town) 54 Middle River		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) 54 Middle River			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 40 4 White Thorn Way				STREET ADDRESS (If rural give location) 4 White Thorn Way			
3. NAME OF DECEASED (First) (Middle) (Last) Mr. William C. Brandau				4. DATE OF DEATH (Month) (Day) (Year) February 2nd 19 56			
5. SEX male		6. COLOR OR RACE white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed		8. DATE OF BIRTH Feb. 16, 1885	
				9. AGE last birthday 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William O. Brandau				14. MOTHER'S MAIDEN NAME Florence Rush			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. 215-22-5651		17. INFORMANT & ADDRESS Mrs. Myrtle B. Young, 44 Kingston Rd.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
430.1 IMMEDIATE CAUSE (A) Coronary Occlusion						6 hours	
ANTECEDENT CAUSE(S) DUE TO (B) Arterio-sclerotic cardiovascular disease						5 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 1954, to Feb. 1956, that I last saw the deceased alive on Feb. 1956, and that death occurred at 11 A.M. from the causes and on the date stated above.							
SIGNATURE Louis Semeroff				ADDRESS (Street, city, town, state) M.D. 1437 Fuselage Ave Baltimore, Md			
DATE Feb 3 1956				DATE SIGNED 2/3/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 6, 1956		NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. REC'D BY REGISTRAR FEB 3 1956		REGISTRAR'S SIGNATURE Mrs. Edith Hurley		25. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road #14			

• **VIEW**

BUREAU A. S.

9661 9 33

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01380

1420

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3003 Acton Rd</u>		STREET ADDRESS (If rural, give location) <u>3003 Acton Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>SUSAN</u>	(First) <u>P</u> (Middle) <u>BRANDT</u> (Last)	4. DATE OF DEATH <u>Feb 19</u>	(Month) (Day) (Year) <u>1956</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH <u>JAN 17 1914</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SEWING</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dress shop</u>	9. AGE last birthday <u>42</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>JOHN BRANDT</u>		14. MOTHER'S MAIDEN NAME <u>SUSAN LUTTMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT <u>LEWIS C. BRANDT</u>		<u>3003 Acton Rd</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

581.0 Immediate cause (a) Cirrhosis of liver
Antecedent cause(s) (b) Hemiplegia
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

INTERVAL BETWEEN ONSET AND DEATH

6 mos

18 mos

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Feb 18, 1956, to Feb 19, 1956, that I last saw the deceased alive on Feb 18, 1956, and that death occurred at 6:50 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

G. M. Bacon, M.D.

2810 Taylor Ctr 2/20/56

23. BURIAL, CREMATION, or other disposition (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>Feb 23 1956</u>	<u>GREEN MOUNT Cemetery</u>	<u>YORK</u>	<u>Penn</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>2/20/56</u>	<u>G. M. Bacon</u>	<u>CHAS. F. EVANS & SON</u>	<u>8802 Hartford Rd.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 23 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1421
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01381

Reg. Dist.

No. 45

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Middle River Helen pt</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Middle River Helen pt</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Beech Drive</u>		STREET ADDRESS (If rural, give location) <u>Beech Drive zone 20.</u>	
3. NAME OF DECEASED: (Type or Print) <u>August</u> (First) <u>Bremer Jr</u> (Middle) <u></u> (Last)		4. DATE OF DEATH <u>2</u> (Month) <u>3</u> (Day) <u>1956</u> (Year)	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>May 16 1912</u>
9. AGE last birthday: <u>43</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Handyman</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Livery Str</u>	
11. BIRTHPLACE (State or foreign country): <u>W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>August Bremer</u>		14. MOTHER'S MAIDEN NAME: <u>Rebecca Gorsuch</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>W.W.II</u>		16. SOCIAL SECURITY No.: <u>216-10-3199</u>	
17. INFORMANT & ADDRESS: <u>See Bremer, 7534 Berkshire Rd.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Occlusion</u>			<u>30 min</u>
DUE TO			
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Paul C. Callen</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>2/7/56</u>	NAME OF CEMETERY OR CREMATORY <u>Map Lawn Cem</u>	LOCATION (City, town, or county) (State) <u>Balto Md</u>
DATE REC'D BY LOCAL REG. <u>2/9/56</u>	REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	24. FUNERAL DIRECTOR <u>Lanshan Funeral Home 7401 Belair Rd</u>	

RECEIVED

FEB 14 1956

BUREAU V. S.

1422

CERTIFICATE OF DEATH

01382

Reg. Dist. No.

Item 8, Film G193 3-6-56 et

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Catonsville LENGTH OF STAY (in this place)
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Home In the Pines. 16 Fustling Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Balto.
 CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville
 STREET ADDRESS (If rural give location) 156 Santard Road

3. NAME OF DECEASED:

(First) (Middle) (Last)
Joseph M. Brokaw

4. DATE OF DEATH: (Month) (Day) (Year)
Feb. 25 1956

5. SEX:

Male

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Status)

Married

8. DATE OF BIRTH:

June 22 1866

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.
89 yrs. Months Days Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:

B.O.R.R.

10b. KIND OF BUSINESS OR INDUSTRY:

B.O.R.R.

11. BIRTHPLACE (State or foreign country):

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA.

13. FATHER'S NAME:

James L. Brokaw

14. MOTHER'S MAIDEN NAME:

Mary E. Wright

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.:

0

17. INFORMANT & ADDRESS:

Mary Hazel Brokaw

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

490X
 Immediate cause (a) LOBAR PNEUMONIA

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) CEREBRAL APOPLEXY° LEFT HEMIPLEGIA- 2 MO
 (c) SENILITY AND ARTERIOSCLEROSIS.

Interval Between Onset And Death

6 days

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

0

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

0

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY 0 m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 17, 1956, to Feb. 25, 1956 that I last saw the deceased

alive on FEB. 24, 1956, and that death occurred at 12:30 P.M. from the causes and on the date stated above.

SIGNATURE Floyd Johnson M.D. ADDRESS 6348 Frederick Road Catonsville DATE SIGNED 2/27/56

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 2/28/56 NAME OF CEMETERY OR CREMATORY Woods Park LOCATION (City, town, or county) Balto. Md. (State)

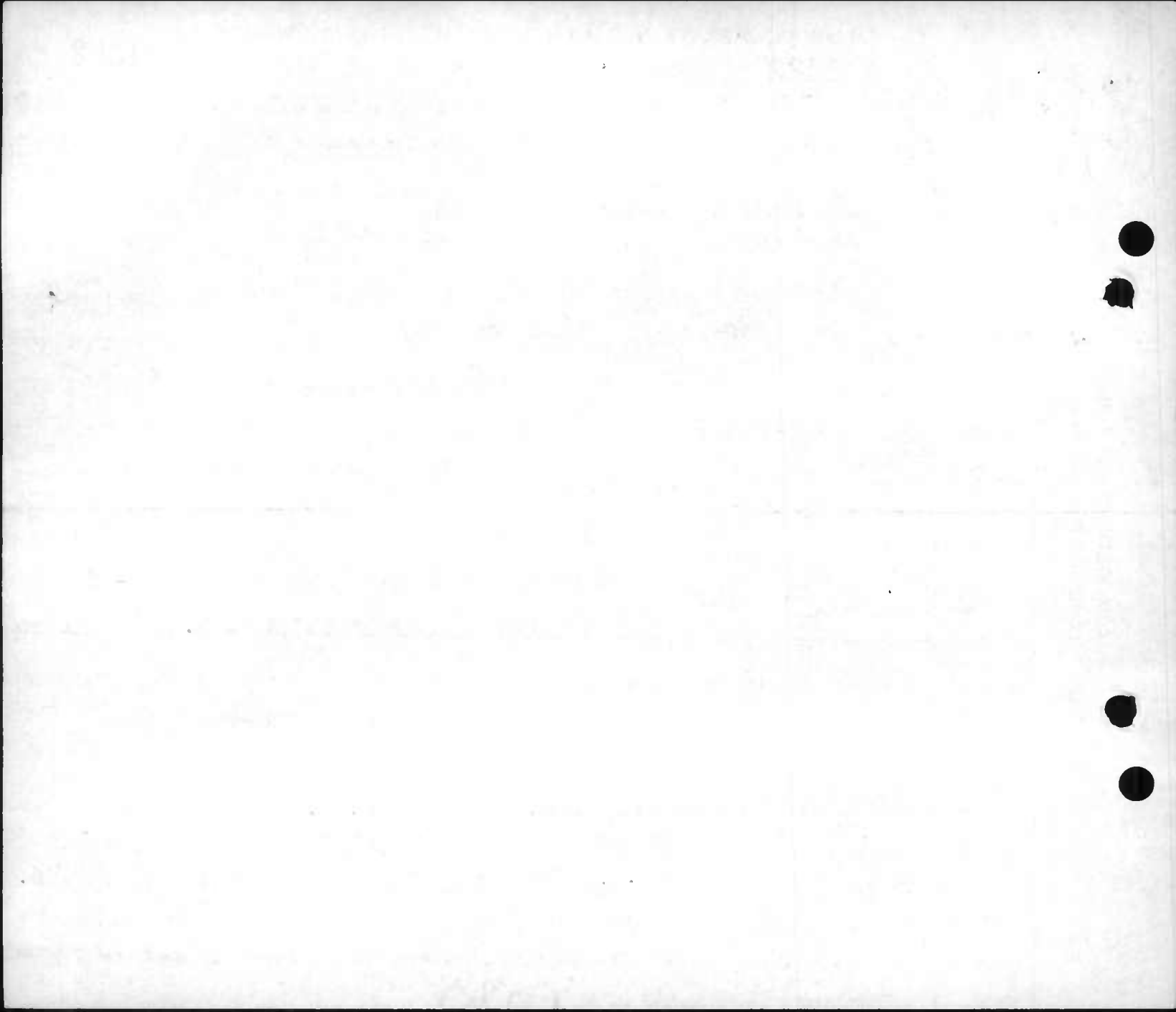
DATE RECD BY LOCAL REGISTRAR 3/28/56 REGISTRAR'S SIGNATURE J. C. Young

24. FUNERAL DIRECTOR

ADDRESS H. B. Hipbert - 1200 E. Eutaw Place

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1423

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01383
Reg. Dist.

No. 45

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN <u>Middle River - 21</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>BALTO. CO. MIDDLE RIVER.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>49 DENTON ROAD.</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Clayton</u>		(Middle) <u>D</u>		(Last) <u>Brown</u>	
5. SEX: <u>m</u>		6. COLOR OR RACE: <u>wh.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>		8. DATE OF BIRTH: <u>Sept 7-1873</u>	
				9. AGE last birthday: <u>82</u> yrs.		4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 20 1956</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>ENGINEER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>B+O. RR</u>		11. BIRTHPLACE (State or foreign country): <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>?</u>				14. MOTHER'S MAIDEN NAME: <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>-</u>		(If Yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY No.: <u>-</u>		17. INFORMANT & ADDRESS: <u>CLARA R. BROWN 49 DENTON ROAD</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH <u>1 -</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p>Immediate cause (a) <u>Chronic myocarditis</u> DUE TO</p> <p>Antecedent cause(s) (b) <u>Sensitivity</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)</p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		19c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	
		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>M. B. Davis M.D.</u>				CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM. <u>2/20/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF <u>2/23/56</u>		NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u>		LOCATION (City, town, or county) (State) <u>WINDSOR MILL RD.</u>	
DATE REC'D BY LOCAL REG. <u>Feb 21, 1956</u>		REGISTRAR'S SIGNATURE <u>G. W. Hedrich</u>		24. FUNERAL DIRECTOR <u>Paul C. Schenck</u>		ADDRESS <u>3615-11 Chestnut Ave.</u>	

1933

1933

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE ASSISTANT SECRETARY FOR CROPS AND LIVESTOCK

WASHINGTON, D. C.

REPORT OF THE ASSISTANT SECRETARY FOR CROPS AND LIVESTOCK

FOR THE YEAR 1933

BY THE ASSISTANT SECRETARY FOR CROPS AND LIVESTOCK

AND THE ASSISTANT SECRETARY FOR CROPS AND LIVESTOCK

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1424

01384

Item 2 Film G193 2-27-56

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Cockeysville</u> TOWN <u>Thos</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Masonic Home</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Baltimore</u> TOWN <u>Thos</u> STREET ADDRESS <u>306 Gittings</u> (If rural give location) <u>Cockeysville</u>			
3. NAME OF DECEASED (Type or Print) <u>Katherine</u> (First) <u>Marie</u> (Middle) <u>Buck</u> (Last)			4. DATE OF DEATH (Month) <u>2</u> (Day) <u>8</u> (Year) <u>1956</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Feb. 27, 1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>			
13. FATHER'S NAME <u>Elmore Buckman</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>L. Grace Buckman, Masonic Home</u>			
18. MEDICAL CERTIFICATION					INTERVAL BETWEEN ONSET AND DEATH <u>7 Mos.</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1 IMMEDIATE CAUSE (A) coronary thrombosis</u>							
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 14, 1955</u> , to <u>Feb. 8, 1956</u> , that I last saw the deceased alive on <u>Feb. 7, 1956</u> , and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Kues</u>			DATE SIGNED <u>2/8/56</u>				
M. D.			ADDRESS (Street, city, town, state)				
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/10/56</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>			
24. REC'D BY REGISTRAR <u>Frank Smith</u>		REGISTRAR'S SIGNATURE		LOCATION (City, town, or county) (State) <u>Woodlawn Maryland</u>			
25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Book Inc.</u>		ADDRESS <u>1217 H. Paul St.</u>					

01324

WASHINGTON STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

DEPT. OF HEALTH

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF DECEASED

12. SIGNATURE OF WITNESS

13. SIGNATURE OF PHYSICIAN

14. SIGNATURE OF CORONER

15. SIGNATURE OF JURY

16. SIGNATURE OF JUDGE

17. SIGNATURE OF CLERK

18. SIGNATURE OF REGISTRAR

19. SIGNATURE OF VENDOR

20. SIGNATURE OF OTHER

BUREAU V. S.

FEB 9 1956

RECEIVED

STANDARDIZATION

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. CAUSE OF DEATH
8. PLACE OF DEATH
9. DATE OF DEATH
10. TIME OF DEATH
11. SIGNATURE OF DECEASED
12. SIGNATURE OF WITNESS
13. SIGNATURE OF PHYSICIAN
14. SIGNATURE OF CORONER
15. SIGNATURE OF JURY
16. SIGNATURE OF JUDGE
17. SIGNATURE OF CLERK
18. SIGNATURE OF REGISTRAR
19. SIGNATURE OF VENDOR
20. SIGNATURE OF OTHER

1425

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Balto.		MARYLAND		STATE Md.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR Balto.		3001-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Smithwood & Summit Ave. Wayne Nursing Home				STREET ADDRESS (If rural give location) 2110 Bolton St.			
3. NAME OF DECEASED: (First) ANNA (Middle) MARIE (Last) BUECHNER		4. DATE OF DEATH: FEB 10 1956		5. AGE last birthday: 78 yrs.		6. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
5. SEX: FEMALE		6. COLOR OR RACE: WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED		8. DATE OF BIRTH: Oct. 21, 1877	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY: at home		11. BIRTHPLACE (State or foreign country): Germany		12. CITIZEN OF WHAT COUNTRY? unknown	
13. FATHER'S NAME: John Malsy				14. MOTHER'S MAIDEN NAME: Kunigunda Hefner			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Mr. Alexander Buechner-2110 Bolton St.			

18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
902.7 Immediate cause Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. 260x				Fracture Hip Right Diabetes Mellitus. Decubitus Ulcers Extensive. Senile Dementia			
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: Nov 2		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) Suicide		PLACE (Home, farm, factory, street, office bldg., etc.) Hospital		CITY OR TOWN Spring Grove State Hosp.		COUNTY Catonsville	
TIME (Month) (Day) (Year) (Hour) 11/17/55		INJURY OCCURRED While at Work		HOW DID INJURY OCCUR? Fell out of Bed			
22. I hereby certify that I attended the deceased from 1. Feb. 1956 to 10. Feb. 1956 , that I last saw the deceased alive on 8 Feb. 1956 , and that death occurred at 7:45 PM , from the causes and on the date stated above.							
SIGNATURE W. L. Smith M.D.		(Degree or title)		ADDRESS 1707 Edmondson Ave. Catonsville 28md		DATE SIGNED 2/10/56	
23. BURIAL, CREMATION, REMOVAL (Specify) Cremation		DATE THEREOF 2/13/56		NAME OF CEMETERY OR CREMATORY Green Mount Crem.		LOCATION (City, town, or county) Balto., Md.	
DATE REC'D BY LOCAL REGISTRAR Feb 11 1956		REGISTRAR'S SIGNATURE R.W.		24. FUNERAL DIRECTOR Wm. J. Vickers & Sons - Balto		ADDRESS 17 Md	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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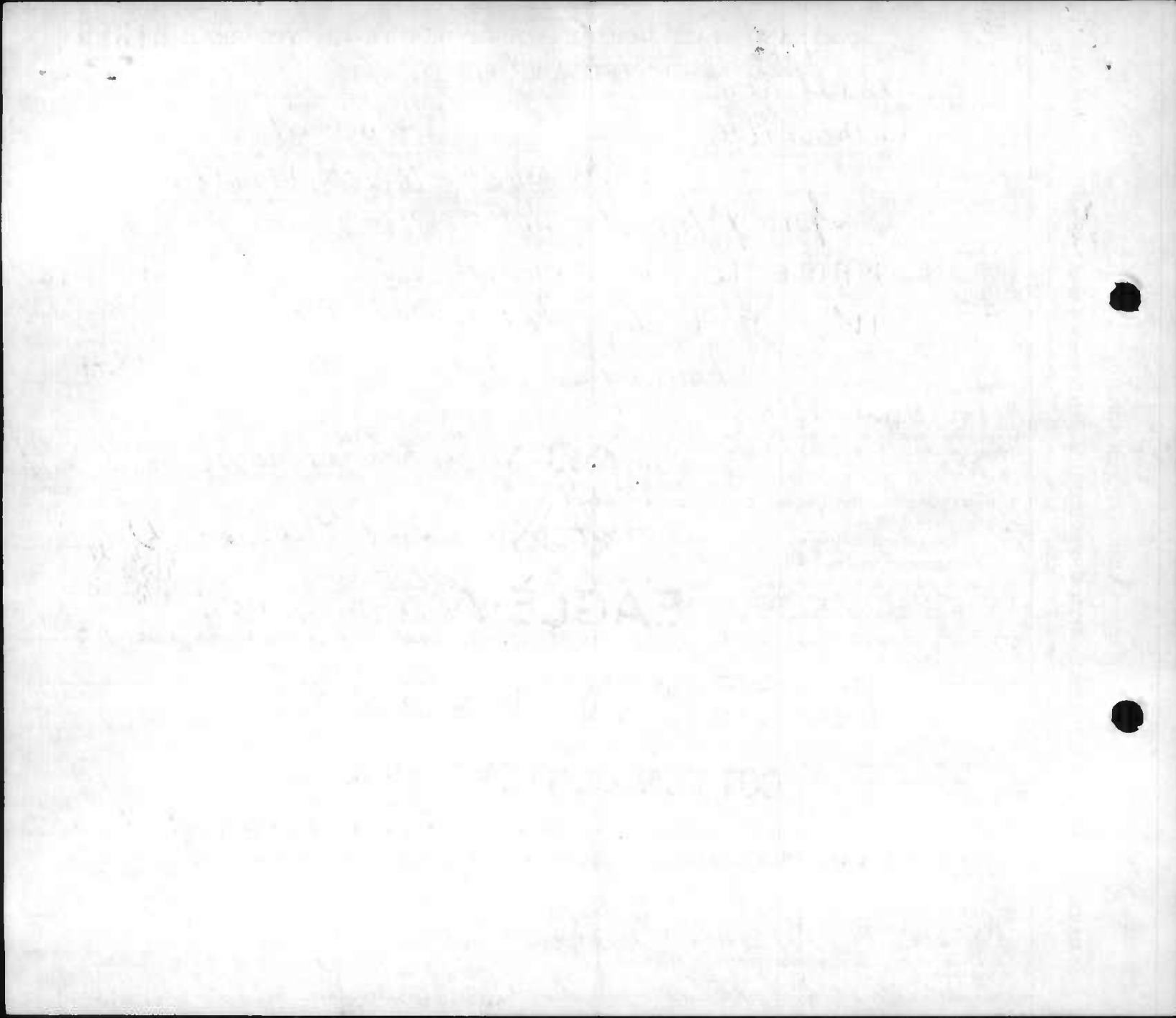
1940

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01386

1426 *Baltimore* CERTIFICATE OF DEATHReg. Dist. No. *32*

1. PLACE OF DEATH: COUNTY <i>Catonsville</i> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Maryland</i> COUNTY <i>Balto.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>522</i> <i>OR TOWN</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>OR TOWN</i> <i>White Marsh</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>14</i> <i>Spring Grove Hospital</i>		STREET ADDRESS (If rural give location) <i>13 Bird River Grove Rd.</i>	
3. NAME OF DECEASED: (Type or Print) <i>MABLE LOUISE CARDWELL.</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>Feb 22 1956</i>	
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Widow</i>	8. DATE OF BIRTH: <i>Sept 1, 1886</i>
9. AGE last birthday <i>69</i> yrs.		10. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY: <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country): <i>Balto., Md.</i>		12. CITIZEN OF WHAT COUNTRY: <i>USA</i>	
13. FATHER'S NAME: <i>Howard Rigg</i>		14. MOTHER'S MAIDEN NAME: <i>Isabelle Heaton</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-10-1206</i>	
17. INFORMANT & ADDRESS: <i>Eleanor Marshall White Marsh, Md.</i>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <i>260X</i>		(A) <i>Acute Myocardial Infarction (Box)</i>	
ANTECEDENT CAUSE (S)		(B) <i>Diabetes Mellitus</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <i>Generalized Atherosclerosis with Hypertension and Cardiac enlargement</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June 18, 1955</i> to <i>Feb 22, 1956</i> , that I last saw the deceased alive on <i>Feb 22, 1956</i> , and that death occurred at <i>11 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>J.R. Cowen</i>		DATE SIGNED <i>2/22/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2/25/56</i>	
NAME OF CEMETERY OR CREMATORY <i>Meadow Ridge</i>		LOCATION (City, town, or county) (State) <i>Relay Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>2-24-56</i>		24. FUNERAL DIRECTOR'S NAME, ADDRESS <i>Balto., Md. S.A. Anderson</i>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02531
Reg. Dist.

No. 38

1. PLACE OF DEATH:

COUNTY **Baltimore** MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN **Towson** LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS **922 Roland View Avenue**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN **Baltimore 1**
STREET ADDRESS (If rural, give location) **507 Myrtle Avenue**

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE OF DEATH

(Month)

(Day)

(Year)

(Type or Print)

WILLIAM

WALTER ALEXANDER

CARROLL

2 9 56

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): **Married**

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Male

Colored

Feb. 19, 1904

51

51

51

51

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

Private-Family

Baltimore, Md

U.S.A

13. FATHER'S NAME:

Unknown

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Maggie Carroll-

Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

DUE TO

Coronary occlusion

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: **Natural causes** ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

CHIEF MEDICAL EXAMINER ☐ DATE SIGNED
DEPUTY MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAM. ☒

M. D.

2/19/56

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2-13-56

Dr. J. A. Medical

Chas. O. Wilson

1000

MARYLAND STATE DEPARTMENT OF HEALTH

01387

2411 N. Charles Street, Baltimore

1428 CERTIFICATE OF DEATH

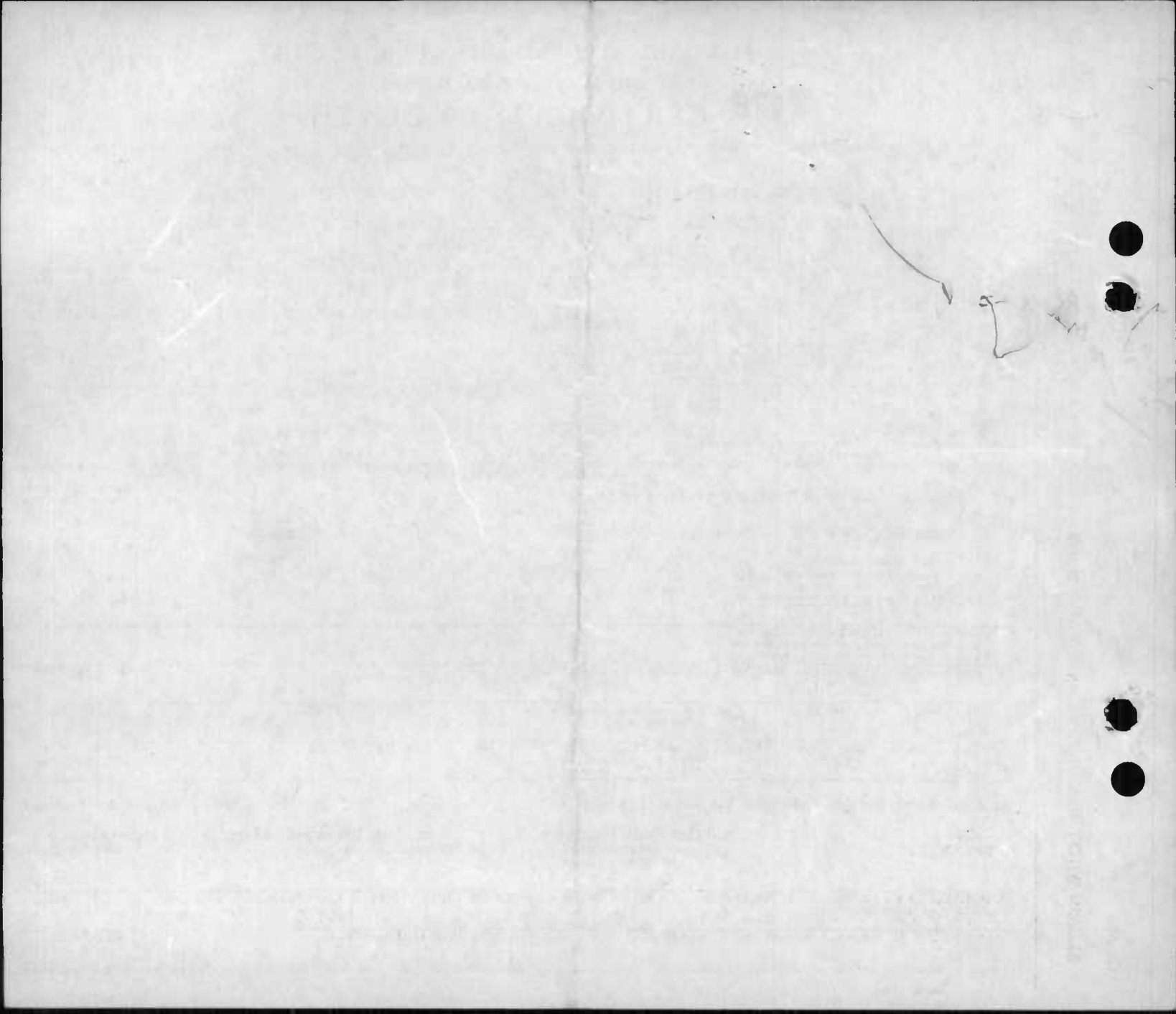
Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>BALTO. CO.</u> MARYLAND <u>MD.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>RURAL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>MT. WASHINGTON</u>	
TOWN <u>RURAL</u>		TOWN <u>MT. WASHINGTON</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6112 FALLS RD.</u>		STREET ADDRESS (If rural, give location) <u>6112 FALLS RD.</u>	
3. NAME OF DECEASED (First) <u>ROBT. FRANKLIN</u> (Middle) <u>CARTER</u> (Last) <u>R.</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>16</u> (Year) <u>1956</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>BR</u>	7. SINGLE, <u>MARRIED</u> , WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>APR 4 - 1910</u>
9. AGE last birthday <u>45</u> yrs. If under 1 year Months <u>10</u> Days <u>10</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WATCHMAN</u>	
11. BIRTHPLACE (State or foreign country) <u>Richmond VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN CARTER</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>FOR DE MONE 10/27/47</u>		16. SOCIAL SECURITY No. <u>214-202975-</u>	
17. INFORMANT AND ADDRESS <u>Wife</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Coronary Occlusion</u>		<u>10 minutes</u>	
Antecedent cause(s) (b) <u>Diabetes</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Obesity</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>246</u>, 19 <u>56</u> , to <u>216</u>, 19 <u>56</u> , that I last saw the deceased alive on <u>216</u>, 19 <u>56</u> , and that death occurred at <u>9:30 PM</u>, from the causes and on the date stated above.			
SIGNATURE <u>Chas. Victor</u>		ADDRESS <u>321 New River Rd. Bz 216</u>	
DATE SIGNED <u>2/16/56</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>2/20/56</u>	
NAME OF CEMETERY OR CREMATORY <u>BALTO. NATIONAL</u>		LOCATION (City, town, or county) <u>BALTO. MD.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE	
FUNERAL DIRECTOR <u>Wm. I. CHATMAN, JR.</u>		ADDRESS <u>1701 McCulloch St. BALTO. MD.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1429

CERTIFICATE OF DEATH

Reg. Dist. No. 38

Item 12, Film GL93 3-5-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
CITY Baltimore		STATE Maryland		COUNTY Baltimore			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Brooklandville,		28 yrs.		TOWN Brooklandville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Falls Road				STREET ADDRESS (If rural give location) Falls Road			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) MARJORIE (Middle) ALICE (Last) CASSELL				(Month) Feb. (Day) 20, (Year) 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	married	March 30, 1880	75 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Housewife				Worcester, England		U.S.A.	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Alfred Lucardo Wells				Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
No		None		W. Barry Cassell, Brooklandville, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422-1 IMMEDIATE CAUSE (A) Cerebral Vascular Accident						10 days	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerotic Cardio-vascular disease							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 15, 1955 , to Feb 20, 1956 that I last saw the deceased alive on Feb 20, 1956 , and that death occurred at 8:00 P.M. from the causes and on the date stated above.							
SIGNATURE Waverly Green, Jr.				DATE SIGNED Feb. 21, 1956			
ADDRESS (Street, city, town, state) M.D. 1725 Reisterstown Road							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Cremation		Feb. 22, 1956		Green Mount Crematory		Baltimore, Maryland	
24. RECEIVED BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
FEB 24 1956		Mrs. Mabel Gray		John O. Mitchell & Sons Inc.,		1900 Butaw Pl.	

Dr. Waverly Green

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH-BALTIMORE 13

Reg. No. 111

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Age (Years, Months, Days)

4. Date of birth (Month, Day, Year)

5. Place of birth (City, State, Country)

6. Usual residence (City, State, Country)

7. Date of death (Month, Day, Year)

8. Time of death (Hour, Minute)

9. Cause of death (Immediate)

10. Cause of death (Underlying)

11. Cause of death (Contributing)

12. Name of physician (Print or write full name)

13. Name of medical examiner (Print or write full name)

14. Name of coroner (Print or write full name)

15. Name of registrar (Print or write full name)

16. Name of funeral director (Print or write full name)

17. Name of cemetery (Print or write full name)

18. Name of place of burial (Print or write full name)

19. Name of place of interment (Print or write full name)

20. Name of place of cremation (Print or write full name)

21. Name of place of entombment (Print or write full name)

22. Name of place of inhumation (Print or write full name)

23. Name of place of disposition (Print or write full name)

24. Name of place of disposal (Print or write full name)

25. Name of place of disposal (Print or write full name)

26. Name of place of disposal (Print or write full name)

27. Name of place of disposal (Print or write full name)

28. Name of place of disposal (Print or write full name)

29. Name of place of disposal (Print or write full name)

30. Name of place of disposal (Print or write full name)

31. Name of place of disposal (Print or write full name)

32. Name of place of disposal (Print or write full name)

33. Name of place of disposal (Print or write full name)

34. Name of place of disposal (Print or write full name)

35. Name of place of disposal (Print or write full name)

36. Name of place of disposal (Print or write full name)

37. Name of place of disposal (Print or write full name)

38. Name of place of disposal (Print or write full name)

39. Name of place of disposal (Print or write full name)

40. Name of place of disposal (Print or write full name)

BUREAU V. S.

FEB 29 1966

RECEIVED

NOTIFICATION

DEPARTMENT OF HEALTH-BALTIMORE 13

1. Name of deceased (Print or write full name)
2. Sex (Male or Female)
3. Age (Years, Months, Days)
4. Date of birth (Month, Day, Year)
5. Place of birth (City, State, Country)
6. Usual residence (City, State, Country)
7. Date of death (Month, Day, Year)
8. Time of death (Hour, Minute)
9. Cause of death (Immediate)
10. Cause of death (Underlying)
11. Cause of death (Contributing)
12. Name of physician (Print or write full name)
13. Name of medical examiner (Print or write full name)
14. Name of coroner (Print or write full name)
15. Name of registrar (Print or write full name)
16. Name of funeral director (Print or write full name)
17. Name of cemetery (Print or write full name)
18. Name of place of burial (Print or write full name)
19. Name of place of interment (Print or write full name)
20. Name of place of cremation (Print or write full name)
21. Name of place of entombment (Print or write full name)
22. Name of place of inhumation (Print or write full name)
23. Name of place of disposition (Print or write full name)
24. Name of place of disposal (Print or write full name)
25. Name of place of disposal (Print or write full name)
26. Name of place of disposal (Print or write full name)
27. Name of place of disposal (Print or write full name)
28. Name of place of disposal (Print or write full name)
29. Name of place of disposal (Print or write full name)
30. Name of place of disposal (Print or write full name)
31. Name of place of disposal (Print or write full name)
32. Name of place of disposal (Print or write full name)
33. Name of place of disposal (Print or write full name)
34. Name of place of disposal (Print or write full name)
35. Name of place of disposal (Print or write full name)
36. Name of place of disposal (Print or write full name)
37. Name of place of disposal (Print or write full name)
38. Name of place of disposal (Print or write full name)
39. Name of place of disposal (Print or write full name)
40. Name of place of disposal (Print or write full name)

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **01389**

1430 CERTIFICATE OF DEATH

Reg. Dist. No. **20**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Balto.		MARYLAND		STATE Md.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3 Vol-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Ridgeway Manor 5743 Edmondson Ave.				STREET ADDRESS (If rural give location) 922 S. Charles St. ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
BERTHA A. CHAMOW				Feb. 26, 19 56			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
female	white	widowed	Feb. 22, 1896	60 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
Housewife at home					Md.		
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Charles H. Heintzeman, Sr.				Amelia Yeakle			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
no		none		Clifton Park Mr. Charles H. Heintzeman-Lake Cottage			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Coronary Occlusion							4 hours
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) Arteriosclerotic Cardio-Vascular Disease							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County)	(State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1954 , 19, to Feb. 26 , 19 56 , that I last saw the deceased alive on Feb. 26 , 19 56 , and that death occurred at 11:30 A M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
Loy M. Zimmerman		M. D. 3202 Hanford Rd.		Feb. 27, 56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		2/29/56		Western Cem.		Balto., Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
2-28-56		C		Wm. J. Dickman & Son Balto. Md.		17	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Ind correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1431

CERTIFICATE OF DEATH

01390

Reg. Dist. No. 31

1. PLACE OF DEATH: Baltimore
 County.....
 City or town Woodlawn
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 18 Years
 Hospital, institution, or street address where death occurred:
201909 Kernan Drive
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Baltimore
 City or town Woodlawn
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1909 Kernan Drive
 (If rural, give LOCATION)
 2.(a) If veteran, name-war... NONE

3. (a) FULL NAME
CHARLES EMORY CHEUVRONT

3. (b) Social Security Number
705-03-8042

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married
 6.(b) Name of husband or wife Stephanie L. Cheuvront
 6.(c) If alive, give age 50 years
 7. Birth date of deceased (mo., day, yr.) September, 20th, 1903
 8. AGE: Years 52 Months 4 Days 26 If less than one day
hrs.min.

9. Birthplace Dickeyville, Balto. Co. Md.
 (Town, county, and state)
 10. Usual occupation Ass't Chief Clerk
 11. Industry or business B. & O. R. R.
 12. Name Charles William Cheuvront
 13. Birthplace Martinsburg, West. Va.
 14. Maiden name Ledie Electra Devese
 15. Birthplace Woodlawn, Balto. Co. Md
 16. Informant Mrs Charles Emory Cheuvront
 Address 1909 Kernan Drive (7)

17. Burial Date thereof Feb. 20, 1956
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Lorraine Park Cemetery
 Location Woodlawn, Balto. Co. Maryland
 18. Funeral director Willis Lamoreau
 Address 4510 Liberty Heights Avenue (7)

19. February 18, 1956
 (Date rec'd by registrar) Registrar P.W.

MEDICAL CERTIFICATION

20. DATE OF DEATH February, 16th., 1956 3.30 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
Dec. 8, 1955 to Feb. 15, 1956
 and that I last saw him alive on Feb. 15, 1956

Immediate cause of death
Coronary thrombosis DURATION 5 min.

Due to Cardio vascular disease 2 mos.

Due to Arterio sclerosis ?

Other conditions 420.1

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

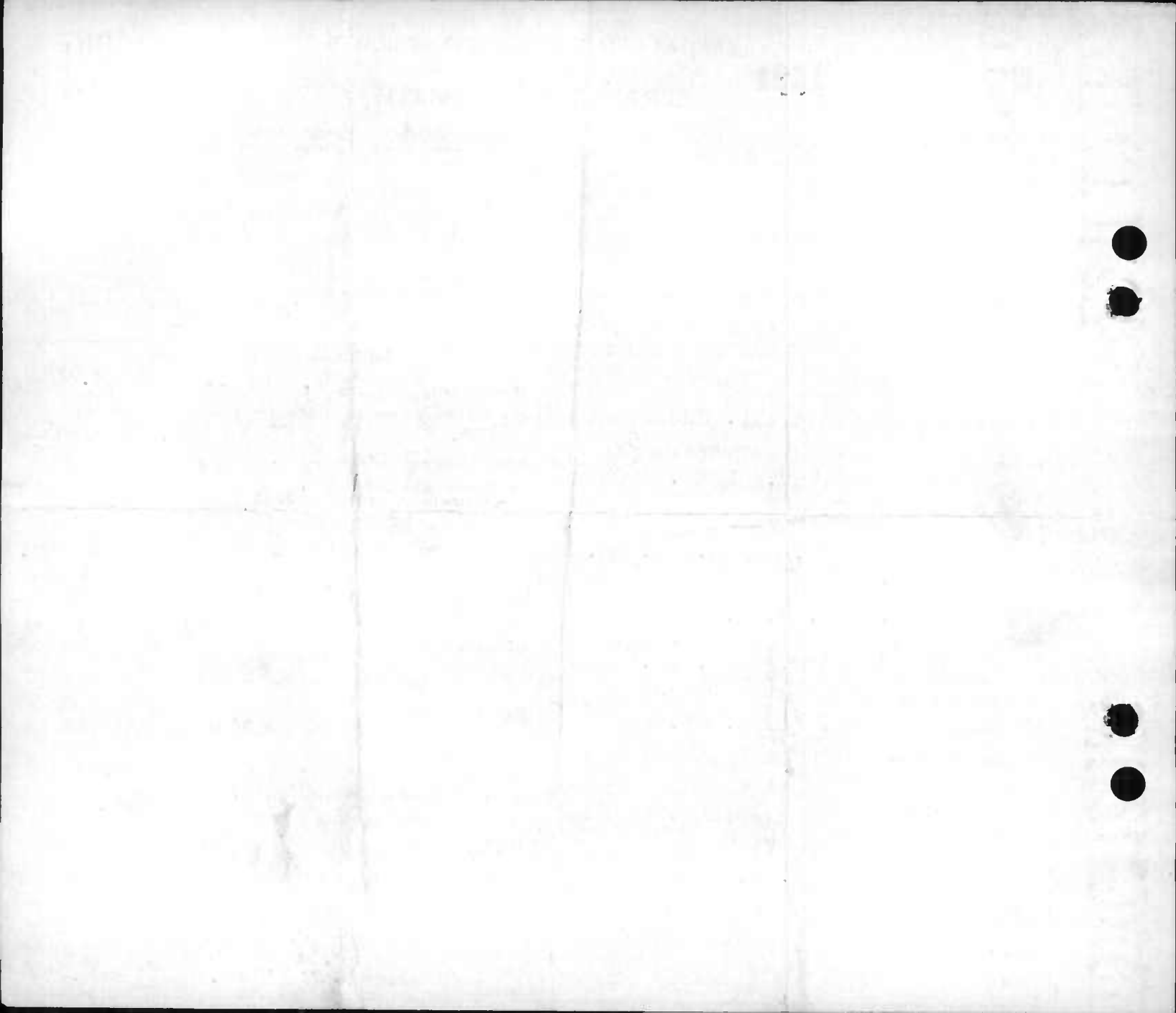
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Charles W. Tublitt M. D. or other

2220 Garrison B'ld. Feb. 17, 1956
 Address..... Date signed.....



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01391

1432 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Balto.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Sparks</i>		LENGTH OF STAY (in this place) <i>37 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Sparks</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Belfast Road</i>				STREET ADDRESS (If rural give location) <i>Belfast Rd.</i>			
3. NAME OF DECEASED (Type or Print) <i>Charles Brooks Chilcoat</i>				4. DATE OF DEATH (Month) <i>February</i> (Day) <i>3</i> (Year) <i>1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH <i>29 June 1888</i>	9. AGE last birthday <i>67</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (State or foreign country) <i>Sparks Balto Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Chilcoat</i>				14. MOTHER'S MAIDEN NAME <i>Ruth Brooks</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>228-09-4544</i>		17. INFORMANT & ADDRESS <i>Wife - Same</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <i>420.1 Coronary thrombosis</i>						INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerotic Cardio-vascular disease</i>						<i>8 yrs</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1948</i> to <i>February</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>3 Feb</i> , 19 <i>56</i> , and that death occurred at <i>11 P</i> .M. from the causes and on the date stated above.							
SIGNATURE <i>Walter T. Kees</i>		M.D. <i>Cockysville Ind</i>		ADDRESS (Street, city, town, state) <i>3 February 1956</i>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2-6-56</i>		NAME OF CEMETERY OR CREMATORY <i>Boslegs Methodist</i>		LOCATION (City, town, or county) (State) <i>Sparks, Balto Co. Md.</i>	
24. REC'D BY REGISTRAR DATE <i>6 Feb 1956</i>		REGISTRAR'S SIGNATURE <i>Nene Armistead MacRae</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>L. Scott Brooks</i>		ADDRESS <i>Sparks, Md.</i>	

1581

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1133 CERTIFICATE OF DEATH

1922

1. NAME OF DECEASED

DATE OF BIRTH	PLACE OF BIRTH	DATE OF DEATH	PLACE OF DEATH

DATE OF DEATH	PLACE OF DEATH	DATE OF BIRTH	PLACE OF BIRTH

DATE OF DEATH	PLACE OF DEATH	DATE OF BIRTH	PLACE OF BIRTH

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DATE OF DEATH	PLACE OF DEATH	DATE OF BIRTH	PLACE OF BIRTH

DATE OF DEATH	PLACE OF DEATH	DATE OF BIRTH	PLACE OF BIRTH

RECEIVED

1. NAME OF DECEASED
2. DATE OF BIRTH
3. PLACE OF BIRTH
4. DATE OF DEATH
5. PLACE OF DEATH
6. CAUSE OF DEATH
7. SEX
8. RACE
9. OCCUPATION
10. MARITAL STATUS
11. EDUCATION
12. RELIGION
13. SERVICE
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15. DATE OF DEATH
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1118. SEX
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1120. OCCUPATION
1121. MARITAL STATUS
1122. EDUCATION
1123. RELIGION
1124. SERVICE
1125. RESIDENCE
1126. DATE OF DEATH
1127. PLACE OF DEATH
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1130. RACE
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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01392

1433 **CERTIFICATE OF DEATH**

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkton Rural</u>		LENGTH OF STAY (in this place) <u>12 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkton Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mt Carmel</u>				STREET ADDRESS (If rural give location) <u>Mt Carmel</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Effie Pearl Chilcoat</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>February 11 19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 22, 1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nicholas Mays</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Wilhelm</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>Aldridge Chilcoat, Parkton Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
154x IMMEDIATE CAUSE (A) <u>Carcinoma Rectum-Primary</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JAN 4, 19 55</u> , to <u>February 11, 19 56</u> , that I last saw the deceased alive on <u>Feb. 11, 19 56</u> , and that death occurred at <u>11:30 A.</u> from the causes and on the date stated above.							
SIGNATURE <u>Joseph E. Bush</u> M.D.				ADDRESS (Street, city, town, state) <u>Hampstead Md</u>		DATE SIGNED <u>2/11/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE OF BURIAL <u>Feb 14/56</u>	NAME OF CEMETERY OR CREMATORY <u>Salem W.B.</u>		LOCATION (City, town, or county) <u>Balto Co Md</u>		(State)	
24. REC'D BY REGISTRAR <u>2-14-56</u>	REGISTRAR'S SIGNATURE <u>Mary B. Elima</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edw C Tipton</u>		ADDRESS <u>Hampstead Md</u>		

CERTIFICATE OF DEATH

33

1. NAME OF DECEASED (Print or Write)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL SOCIETY

16. SIGNATURE OF CHURCH

17. SIGNATURE OF CEMETERY

18. SIGNATURE OF FUNERAL HOME

19. SIGNATURE OF MINISTERS

20. SIGNATURE OF OTHERS

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180. SIGNATURE OF OTHERS

181. SIGNATURE OF DECEASED

182. SIGNATURE OF NEXT OF KIN

183. SIGNATURE OF BURIAL SOCIETY

184. SIGNATURE OF CHURCH

185. SIGNATURE OF CEMETERY

186. SIGNATURE OF FUNERAL HOME

187. SIGNATURE OF MINISTERS

188. SIGNATURE OF OTHERS

189. SIGNATURE OF DECEASED

190. SIGNATURE OF NEXT OF KIN

191. SIGNATURE OF BURIAL SOCIETY

192. SIGNATURE OF CHURCH

193. SIGNATURE OF CEMETERY

194. SIGNATURE OF FUNERAL HOME

195. SIGNATURE OF MINISTERS

196. SIGNATURE OF OTHERS

197. SIGNATURE OF DECEASED

198. SIGNATURE OF NEXT OF KIN

199. SIGNATURE OF BURIAL SOCIETY

200. SIGNATURE OF CHURCH

201. SIGNATURE OF CEMETERY

202. SIGNATURE OF FUNERAL HOME

203. SIGNATURE OF MINISTERS

204. SIGNATURE OF OTHERS

205. SIGNATURE OF DECEASED

206. SIGNATURE OF NEXT OF KIN

207. SIGNATURE OF BURIAL SOCIETY

208. SIGNATURE OF CHURCH

209. SIGNATURE OF CEMETERY

210. SIGNATURE OF FUNERAL HOME

211. SIGNATURE OF MINISTERS

212. SIGNATURE OF OTHERS

213. SIGNATURE OF DECEASED

214. SIGNATURE OF NEXT OF KIN

215. SIGNATURE OF BURIAL SOCIETY

216. SIGNATURE OF CHURCH

217. SIGNATURE OF CEMETERY

218. SIGNATURE OF FUNERAL HOME

219. SIGNATURE OF MINISTERS

220. SIGNATURE OF OTHERS

221. SIGNATURE OF DECEASED

222. SIGNATURE OF NEXT OF KIN

223. SIGNATURE OF BURIAL SOCIETY

224. SIGNATURE OF CHURCH

225. SIGNATURE OF CEMETERY

226. SIGNATURE OF FUNERAL HOME

227. SIGNATURE OF MINISTERS

228. SIGNATURE OF OTHERS

229. SIGNATURE OF DECEASED

230. SIGNATURE OF NEXT OF KIN

231. SIGNATURE OF BURIAL SOCIETY

232. SIGNATURE OF CHURCH

233. SIGNATURE OF CEMETERY

234. SIGNATURE OF FUNERAL HOME

235. SIGNATURE OF MINISTERS

236. SIGNATURE OF OTHERS

237. SIGNATURE OF DECEASED

238. SIGNATURE OF NEXT OF KIN

239. SIGNATURE OF BURIAL SOCIETY

240. SIGNATURE OF CHURCH

241. SIGNATURE OF CEMETERY

242. SIGNATURE OF FUNERAL HOME

243. SIGNATURE OF MINISTERS

244. SIGNATURE OF OTHERS

245. SIGNATURE OF DECEASED

246. SIGNATURE OF NEXT OF KIN

247. SIGNATURE OF BURIAL SOCIETY

248. SIGNATURE OF CHURCH

249. SIGNATURE OF CEMETERY

250. SIGNATURE OF FUNERAL HOME

251. SIGNATURE OF MINISTERS

252. SIGNATURE OF OTHERS

253. SIGNATURE OF DECEASED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01393

1434 CERTIFICATE OF DEATH

Reg. Dist. No. *X*

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN FORT HOWARD	LENGTH OF STAY (In this place) 35 5/4 Days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE <i>3401-4</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) 2746 WINCHESTER St.	
3. NAME OF DECEASED: (Type or Print) JAMES (First) (Middle) (Last) CLEVELAND		4. DATE (Month) (Day) (Year) OF DEATH: February 24 19 56	
5. SEX: MALE	6. COLOR OR RACE: COLORED	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE	8. DATE OF BIRTH: 8/14/1892 1890 65 yrs. 68 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: 65 Months Days Hours Min.
11. BIRTHPLACE (State or foreign country): UNION, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: JOHN CRAWFORD CLEVELAND		14. MOTHER'S MAIDEN NAME: ALANA NOTCH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: CLIN. REC. VET. ADM. HOSP., FT. HOWARD, MD.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) FAR ADVANCED TUBERCULOSIS LEFT LUNG		UNKNOWN	
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 20, 19 56 to Feb. 24, 19 56, and that death occurred at 7:15 P. M., from the causes and on the date stated above.			
SIGNATURE DONALD D. MARK, M. D.		ADDRESS VAH, Fort Howard, Md. DATE SIGNED 2/25/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2/28/56	
NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR 2-27-56		REGISTRAR'S SIGNATURE R. W. Hedrick	
24. FUNERAL DIRECTOR Charles R. Law		ADDRESS Funeral Home 802-04 Madison Ave., Balto., Md.	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55-7046

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01394

1435 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town)			
TOWN <u>Fort Howard</u>		<u>971 Days</u>		TOWN <u>Annapolis</u>		<u>02-10-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>321 First Street</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>LAWRENCE</u>		(Middle) <u>W.</u>		(Last) <u>COLLISON</u>		(Month) (Day) (Year) <u>February 28 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>September 19, 1899</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Handy Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Mayo, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Collison</u>				14. MOTHER'S MAIDEN NAME <u>Ida B. Gardiner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
527.1 IMMEDIATE CAUSE (A) <u>PULMONARY EMPHYSEMA</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>HEALED FIBROCASEOUS TUBERCULOSIS</u>						UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>1. COR PULMONALE 2. CIRRHOSIS OF LIVER</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 2</u> , 19 <u>53</u> , to <u>Feb. 28</u> , 19 <u>56</u> , and that death occurred at <u>9:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>D. D. MARK, M.D.</u>				ADDRESS (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>2-29-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-2-56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery Baltimore, Maryland</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>MAR 3 1956</u>		REGISTRAR'S SIGNATURE <u>L. L. Larkins</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight Inc</u>		ADDRESS <u>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. Md.</u>	

CERTIFICATE OF DEATH

City of Baltimore

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BUREAU V. S.

MAR 6 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01395

1436

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTIMORE		STATE MARYLAND		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN FORT HOWARD		60 Days		TOWN BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) 812 E. LOMBARD STREET			
3. NAME OF DECEASED (First) (Middle) (Last) FRANCIS P. CONNOR				4. DATE OF DEATH (Month) (Day) (Year) February 10, 1956			
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED	8. DATE OF BIRTH JULY 30, 1893	9. AGE last birthday 62 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEWARD		10b. KIND OF BUSINESS OR INDUSTRY STEAMSHIP LINE		11. BIRTHPLACE (State or foreign country) BROOKLYN, N. Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PATRICK CONNOR				14. MOTHER'S MAIDEN NAME ANNA KILLIAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk) YES (If Yes, give year or dates of service) WW-1		16. SOCIAL SECURITY NO. 054-07-1828		17. INFORMANT & ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
150x IMMEDIATE CAUSE (A) CARCINOMA ESOPHAGUS						1 YEAR (?)	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION 12-29-55		19b. MAJOR FINDINGS OF OPERATION GASTROSTOMY				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that VA attended the deceased from 12-12-55 to 2-10-56, and that death occurred at 3:15 P.M. from the causes and on the date stated above.							
SIGNATURE C. S. CORE, M.D.				DATE SIGNED 2-12-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				DATE THEREOF 2-15-56			
24. REC'D BY REGISTRAR Feb. 14, 1956				NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY BALTIMORE MARYLAND			
25. FUNERAL DIRECTOR'S SIGNATURE William Cook-Blight Inc. Funeral Home				ADDRESS 6009 Harford Rd., Baltimore 14, Md.			

8961-70-2041

BUREAU V. S.

FEB 15 1956

RECEIVED

1437 CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR TOWN) <u>Towson</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u>	55
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>713 Hillen Road</u>		STREET ADDRESS (If rural give location) <u>713 Hillen Rd</u>	1
3. NAME OF DECEASED: (First) <u>MARY</u> (Middle) <u>MATILDA</u> (Last) <u>CROWHART</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>2</u> <u>12</u> <u>1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>w</u>	7. SINGLE. MARRIED. WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Aug. 20, 1982</u>
9. AGE last birthday: <u>73</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Salisbury, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Peter Clement Liggett</u>		14. MOTHER'S MAIDEN NAME: <u>Matilda C. Liggett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>—</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT & ADDRESS: <u>Robinson Crowhart 713 Hillen Rd. Towson Md</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
414X IMMEDIATE CAUSE (A) <u>Cardiac Decompensation</u>			
ANTECEDENT CAUSE (S) DUE TO <u>Valvular disease of Heart</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Pneumonia</u>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>56</u> , to <u>2/12</u> , 19 <u>56</u> that I last saw the deceased alive on <u>2/11/56</u> , 19 <u>56</u> , and that death occurred at <u>10:31 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Dennis J. McGrath</u>		DATE SIGNED <u>2/12/56</u>	
ADDRESS <u>M.D. 8358 Loch Raven Blvd</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>Feb 14, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Woodfield</u>		LOCATION (City, town, or county) (State) <u>Salisbury, Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/12/56</u>		REGISTRAR'S SIGNATURE <u>Dennis J. McGrath</u>	
24. FUNERAL DIRECTOR <u>Bernard Hardisty</u>		ADDRESS <u>Salisbury, Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Valley 6/18

Right on Parks are to Hillen

John Louis Crouhardt

Tuesday 11 A.M.

Simpson & Capital
Ballbearers

RECEIVED

FEB 16 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1438 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN <u>Ruxton</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	3101-4
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 <u>Sorrenson Nursing Home</u> <u>7912 Ruxway</u>		STREET ADDRESS (If rural give location) <u>1813 East 32nd Street</u>	✓
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ALONZA W. CROSS</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb. 19</u> , 19 <u>56</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Sept. 18, 1882</u>
9. AGE last birthday <u>73</u> yrs.		IF UNDER 1 YEAR: Months <u>5</u> Days <u>1</u>	IF UNDER 24 HRS.: Hours <u>1</u> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plasterer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Building Const.</u>	11. BIRTHPLACE (State or foreign country): <u>West Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Daniel Cross</u>	
14. MOTHER'S MAIDEN NAME: <u>---</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service) <u>---</u>	
16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS: <u>Lyle W. Cross, 4521 Shamrock Avenue</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
199.1 IMMEDIATE CAUSE (A) <u>Metastasis carcinoma</u>			<u>6 months</u>
ANTECEDENT CAUSE (B) <u>Carcinoma neck right.</u>			<u>3 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Myocarditis with failure</u>			<u>5 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>General malnutrition</u>			<u>3 yrs.</u>
19A. DATE OF OPERATION: <u>none</u>	19B. MAJOR FINDINGS OF OPERATION: <u>none. Treated University Hospital Balto. Md</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>no injury</u>	21C. WHERE DID (City or town) INJURY OCCUR? <u>no injury</u>	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>no injury</u> M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? <u>no injury</u>	
22. I hereby certify that I attended the deceased from <u>Oct 19, 1955</u> to <u>Feb 19, 1956</u> , that I last saw the deceased alive on <u>Feb 16, 1956</u> , and that death occurred at <u>8:30 M.</u> from the causes and on the date stated above. <u>56</u>			
SIGNATURE <u>Jarvis Graham Marton, M.D.</u>		DATE SIGNED <u>Feb 21, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>	DATE THEREOF <u>2/22/56</u>	NAME OF CEMETERY OR CREMATORY <u>Moreland Park Cemetery</u>	LOCATION (City, town, or county) (State) <u>Parkville, Maryland</u>
DATE REC'D BY LOCAL REGISTRAR <u>Feb 21, 1956</u>	REGISTRAR'S SIGNATURE <u>A. L. Hedrick</u>	24. FUNERAL DIRECTOR <u>Wm. Cook, Inc.</u>	ADDRESS <u>1217 St. Paul St.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

COMMITTEE OF THE SENATE

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THE STATE DEPARTMENT OF REVENUE

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 402

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto</i>	MARYLAND	STATE <i>MD</i>	COUNTY <i>Balto</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>51</i> TOWN <i>Arbutus</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <i>Arbutus</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>1219 Maiden Chica Rd</i>		STREET ADDRESS (If rural, give location) <i>1219 Maiden Chica Lane</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>William S.</i>	(Middle) <i>Cullen</i>	(Last) <i>1956</i>	
(Type or Print)			
5. SEX: <i>m</i>	6. COLOR OR RACE: <i>w</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH: <i>Sept 8, 1905</i>
			9. AGE last birthday: <i>48</i> yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>Self</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Self</i>	11. BIRTHPLACE (State or foreign country): <i>Balto</i>
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
13. FATHER'S NAME: <i>William Cullen</i>		14. MOTHER'S MAIDEN NAME: <i>Mudd</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>yes</i> (If Yes, give war or dates of service) <i>WWII</i>		16. SOCIAL SECURITY No.: <i>713019449</i>	
		17. INFORMANT & ADDRESS: <i>Edna M Cullen 1219 Maiden Chica Lane</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) DUE TO <i>Coronary Thrombosis</i>		
Antecedent cause(s) (b) DUE TO <i>Coronary Thrombosis</i>		
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office hldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <i>Le. Postkoffer</i>	1010 Leiden	CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>2-1-56</i> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF: <i>2-4-56</i>	NAME OF CEMETERY OR CREMATORY: <i>London Park</i>
LOCATION (City, town, or county) (State): <i>Balto MD</i>	24. FUNERAL DIRECTOR: <i>Howard H. Hubbard</i>	ADDRESS: <i>4107 Milken ave</i>
DATE REC'D BY LOCAL REG. <i>Feb 2 56</i>	REGISTRAR'S SIGNATURE: <i>Le. Postkoffer</i>	

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 6 1938

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01399

1439 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Pg.</u>	COUNTY <u>Burkes</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>55 Towson</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Reading</u>	<u>75 x - 3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1721 Glen Ridge Rd.</u>		STREET ADDRESS (If rural give location) <u>1338 Mineral Spring Rd.</u>	<u>✓</u>
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>George</u>	(Middle) <u>Washington</u>	(Last) <u>Davis</u>	(Date) <u>Feb. 4,</u> (Year) <u>1956</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>July 1, 1874</u>
9. AGE last birthday <u>81</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>tailor-ret. Retail Clothing</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Penna.</u>	
11. BIRTHPLACE (State or foreign country): <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Franklin Davis</u>		14. MOTHER'S MAIDEN NAME: <u>Emma James</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Mrs. W.B. Shoemaker - 1721 Glen Ridge Towson, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE: <u>Cerebro vascular accident</u>		<u>3 days</u>	
(B) ANTECEDENT CAUSE (S): <u>Arterio sclerotic Cardiovascular disease</u>			
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1/15</u> , 19 <u>56</u> , to <u>2/4</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/4</u> , 19 <u>56</u> , and that death occurred at <u>5:20</u> P. M., from the causes and on the date stated above.			
SIGNATURE <u>Gordon Grant</u>		DATE SIGNED <u>2/5/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Removal</u>		24. FUNERAL DIRECTOR ADDRESS	
DATE REC'D BY LOCAL REGISTRAR <u>2/7/56</u>		REGISTRAR'S SIGNATURE <u>G.M. Bacon</u>	
NAME OF CEMETERY OR CREMATORY <u>Miller Funeral Home</u>		LOCATION (City, town, or county) (State) <u>Reading, Penna.</u>	
25. FUNERAL DIRECTOR ADDRESS		26. FUNERAL DIRECTOR ADDRESS	

RECEIVED
FEB 9 1956
BUREAU V. 8

1333 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>53</u> TOWN <u>Dundalk</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>53</u> TOWN <u>Dundalk</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2914 Dunmurray Road</u>				STREET ADDRESS (If rural give location) <u>2914 Dunmurray Road</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <u>JOHN</u>		(Middle) <u>MELVIN</u>		(Last) <u>DAVIS</u>		(Month) (Day) (Year) <u>Feb. 4, 1956</u>	
(Type or Print)							
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Jan. 22, 1879</u>	
						9. AGE last birthday: <u>77</u> yrs.	
						10. MONTHS <u>7</u> DAYS <u>19</u> HRS. <u>19</u> MIN.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>George H. Davis</u>				14. MOTHER'S MAIDEN NAME: <u>Adeline Lilly</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS: <u>Dr. M.B. Davis 6800 Mornington Road. 22</u>			
16. SOCIAL SECURITY No.:							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>Arterio-Sclerotic-Cardio-Vascular</u>							
Antecedent causes (s) (b) <u>Renal Disease</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>None</u>							
19a. DATE OF OPERATION: <u>Jan 4, 1956</u> 19b. MAJOR FINDINGS OF OPERATION <u>None</u>							
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 22, 1956</u> to <u>Feb. 4, 1956</u> that I last saw the deceased alive on <u>Feb. 4, 1956</u> and that death occurred at <u>6:15 Pm</u> , from the causes and on the date stated above.							
SIGNATURE <u>M. B. Davis</u>		(Degree or title)		ADDRESS <u>6800 Mornington Road - Dundalk - 75/56</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 7, 1956</u>		<u>Trinity Episcopal Church</u>		<u>Churchville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Feb 6, 1956</u>		<u>A. W. Hedrich</u>		<u>Ullrich Funeral Home</u>		<u>2112 Dundalk Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

100

4

1441 CERTIFICATE OF DEATH

Reg. Dist. No. 40

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	OR TOWN
X TOWN <u>Balto Co md</u>	<u>Life</u>	TOWN <u>Balto Co md</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>2809 E Joppa Rd</u>		<u>2809 E Joppa Rd</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)	4. DATE (Month) (Day) (Year)		
(Type or Print) <u>Clarence E Debring</u>	OF DEATH: <u>Feb 6 1956</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE MARRIED. (Specify):	8. DATE OF BIRTH:
<u>male</u>	<u>white</u>	<u>WIDOWED</u>	<u>Dec 7-1877</u>
9. AGE last birthday		IF UNDER 1 YEAR	
<u>78</u> yrs.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>Shopping Clerk Koppers Co.</u>		<u>Balto md</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Balto md</u>		<u>USA</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Anthony Debring</u>		<u>Regina Klueber Spies</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
<u>No</u>		<u>215-07-6258</u>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Meta Kneafle 2809 E Joppa Rd</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
450.0		IMMEDIATE CAUSE (A) <u>Cardiac decompensation</u>	
ANTECEDENT CAUSE (B) <u>and Congestive Failure</u>		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>Cachexia & arteriosclerosis</u>	
DUE TO		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 19 55</u> , to <u>Feb 6 1956</u> , that I last saw the deceased alive on <u>Feb 6, 1956</u> , and that death occurred at <u>9:00 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Frank A. Karik</u>		ADDRESS <u>9005 Haford Rd</u>	
DATE SIGNED <u>2/18/56</u>		M. D. <u>9005 Haford Rd</u>	
23. BURIAL, CREMATION, REMOVAL, (SPECIFY)		DATE THEREOF	
<u>Burial</u>		<u>2/9/56</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Parkwood Cen</u>		<u>Balto md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
<u>2-9-56</u>		<u>Mr. Hammett</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>Lassahn Funeral Home</u>		<u>7401 Belair Rd.</u>	

MARGIN RESERVED FOR BINDING

Dr Kasik
9005 Harvard Rd

BUREAU V. S.

FEB 21 1956

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE Md	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Catonsville	LENGTH OF STAY (in this place) 1 year	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Catonsville	52
HOSPITAL OR INSTITUTION OR STREET ADDRESS 112 Malbrook Road		STREET ADDRESS (If rural, give location) 112 Malbrook Road	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
LILLIAN C. DEICHMÖLLER		FEB 3 1956	
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED: (Specify) Married Aug 17, 1899	8. DATE OF BIRTH:
			9. AGE last birthday: 56 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Clerk		10b. KIND OF BUSINESS OR INDUSTRY: Roads Dept	
11. BIRTHPLACE (State or foreign country): Baltimore Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Bernard J. Connolly		14. MOTHER'S MAIDEN NAME: Rose Short	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: 2016-36-8958	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: William B. Connolly 1605 Shadyside Rd	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE		
Antecedent cause(s) (b) DUE TO		
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office hldg., etc., INJURY)	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		
SIGNATURE Paul F. Kerner		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 2-4-56 DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF Feb 7-1956	NAME OF CEMETERY OR CREMATORY Landon Park
DATE REC'D BY LOCAL REG. 2/6/56	REGISTRAR'S SIGNATURE V.E. Harris	24. FUNERAL DIRECTOR John G. Griefel
		ADDRESS 5311 Edmondson Ave

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 8 1956

RECEIVED

1443

CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH o. COUNTY <u>Balto.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>54 Essex</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u> <u>54</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>313 Lorraine Ave</u>				d. STREET ADDRESS <u>313 Lorraine Ave</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>E.</u> Last <u>Diggs</u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>29th</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct 8th 1896</u>	
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u>29</u> Days <u>29</u> Hours <u>29</u> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Adam Hartman</u>				14. MOTHER'S MAIDEN NAME <u>Eva H. Lechter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>311 Lorraine Essex Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>Hypertensive Cardio-Vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>obese</u> (c) <u>obese</u>				INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> <u>9 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>April</u> , 19 <u>55</u> , to <u>Feb 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 29</u> , 19 <u>56</u> , and that death occurred at <u>5:55 P.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Joseph Niceli</u> M.D.				ADDRESS (Street, city or town, state) <u>423 Eastern Ave</u>			
PHYSICIAN'S NAME (Type) <u>JOSEPH NICELE M.D.</u>				DATE SIGNED <u>3/1/56</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. City Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lillian Turner</u>				ADDRESS <u>7401 Belair Rd</u>		24a. REC'D BY REGISTRAR DATE <u>5</u> 19 <u>56</u>	
24b. REGISTRAR'S SIGNATURE <u>Edith Hurley</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
1913
CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, date of death, and cause of death. The form is mostly blank with some faint markings.

BUREAU V. S.

MAR 5 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, pages 1 and 2 should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01405

1444

CERTIFICATE OF DEATH

Reg. Dist. No.

45

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u> <u>54</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>00</u>		d. STREET ADDRESS <u>301 CANDRY TERRACE</u>	
3. NAME OF DECEASED (Type or print) First <u>CASIMIR</u> Middle <u>DOLATA</u> Last <u>DOLATA</u>		4. DATE OF DEATH Month <u>2</u> Day <u>22</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 12, 1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>22</u> Days <u>22</u> Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>POLAND</u>	
11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>123-09-1584A</u>	
17. INFORMANT <u>Michaelina Dolata</u>		Address <u>(Same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardiac failure</u> DUE TO (c) <u>Cardio-vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2-21-56</u> <u>2-20-56</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>11</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-20</u> , 19 <u>56</u> , to <u>2-22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-22</u> , 19 <u>56</u> , and that death occurred at <u>6:15</u> AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maxwell H. Mund</u> M.D.		ADDRESS (Street, city or town, state) <u>417 1/2 Eastern Ave, Essex, Md.</u>	
DATE SIGNED <u>2-23-56</u>			
PHYSICIAN'S NAME (Type) <u>MAXWELL H. MUND</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-25-1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Connelly</u>		ADDRESS <u>Essex Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE 27 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mrs. Edith Harkys</u>	

BUREAU V. S.

FEB 28 1956

RECEIVED

1445

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 52 CATONSVILLE		c. LENGTH OF STAY IN 1b 2 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 204 WINTERS LANE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ELLA Middle BRUNER Last DORSEY		4. DATE OF DEATH Month FEB. Day 16th, Year 1956	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/10/1901
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY DOMESTIC	
11. BIRTHPLACE (State or foreign country) FREDERICK COUNTY, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES BRUNER		14. MOTHER'S MAIDEN NAME CLARA NORRIS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT JOHN H. DORSEY-204 WINTERS LANE.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Nephromegaly Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Nephromegaly DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes		INTERVAL BETWEEN ONSET AND DEATH 7 days 5-6 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 16, 1955 to 16 Nov 1956 , that I last saw the deceased alive on 16 Nov 1956 , and that death occurred at 4:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Charles R. Davidson		M.D. 305 WINTERS LANE	
PHYSICIAN'S NAME (Type) CHARLES R. DAVIDSON M.D.		305 WINTERS LANE, CATONSVILLE, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 2/20/56	22c. NAME OF CEMETERY OR CREMATORY BALTO. NAT'L. CEM.	22d. LOCATION (City, town, or county) (State) BALTO. CITY, MD.
23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Harkew-512 (Annetta Ave)		24a. REC'D BY REGISTRAR FEB 20 1956	
		24b. REGISTRAR'S SIGNATURE V.E. Harry	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and the funeral director must sign the certificate. After the certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9 8

1

FEB 20 1956

RECEIVED

1530

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH a. COUNTY <i>Balto</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Balto</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>x Upperco (Rural)</i>				c. LENGTH OF STAY IN 1b <i>13 yrs</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>00</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>SALLIE - M - POSTER</i>				4. DATE OF DEATH <i>Feb 24 1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Nov 2-1871</i>		9. AGE (In years last birthday) <i>84</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housework</i>		11. BIRTHPLACE (State or foreign country) <i>MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Henry Forchman</i>				14. MOTHER'S MAIDEN NAME <i>Lydia Hoover</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>Mrs Earl Greene, Upperco MD</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Pharynx - metastatic</i> DUE TO 148X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>6 mo</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 1956</i> to <i>Feb 24 56</i> , that I last saw the deceased alive on <i>Feb 23 1956</i> , and that death occurred at <i>11a</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>M. C. Porterfield</i>				ADDRESS (Street, city or town, state) <i>Hampstead, Md.</i>		DATE SIGNED <i>2/25/56</i>	
PHYSICIAN'S NAME (Type) <i>M. C. PORTERFIELD, M.D.</i>				HAMPSTEAD, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>Feb 26/56</i>		<i>Stiltz</i>		<i>York Co - Pa</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edw Clifton</i>				ADDRESS <i>Hampstead Md</i>		24a. REC'D BY REGISTRAR DATE <i>2-24-56</i>	
						24b. REGISTRAR'S SIGNATURE <i>Mary B. Blue</i>	

MEDICAL CERTIFICATION

FEB 28 1958

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01407

1446

CERTIFICATE OF DEATH

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Bentley Springs</u>		LENGTH OF STAY (in this place) <u>75 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Bentley Springs</u>			
TOWN				TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Morgan E.</u> (Middle) <u>Doster.</u> (Last)				(Month) <u>Febr.</u> (Day) <u>17</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 7, 1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Track Foreman Railroad</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Parkton, Md. R.D. 4, S.A.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Edward Doster</u>				14. MOTHER'S MAIDEN NAME <u>Mary Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>717-07-6781</u>		17. INFORMANT & ADDRESS <u>Mrs. Bessie Doster, Bentley Springs, Md.</u>			
(If Yes, give war or dates of service)							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
434.1 IMMEDIATE CAUSE (A) <u>Acute congestive heart failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
260X (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Diabetes Mellitus</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-30-</u> , 19 <u>55</u> , to <u>2-17-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-17-</u> , 19 <u>56</u> , and that death occurred at <u>9:53 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>R. Robinson</u>				ADDRESS (Street, city, town, state) <u>New Freedom, Pa.</u>		DATE SIGNED <u>2-18-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Febr. 20, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>		LOCATION (City, town, or county) (State) <u>Freeland Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Charles L. Gustafson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Hartenstein</u>		ADDRESS <u>New Freedom, Pa.</u>	
DATE <u>20/2/56</u>							

100-100000

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

CERTIFICATE OF DEATH

Local Death No.

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Date of death

7. Place of death

8. Cause of death

9. Manner of death

10. Signature of physician

11. Signature of coroner

12. Signature of registrar

13. Signature of informant

14. Signature of witness

15. Signature of funeral director

16. Signature of undertaker

17. Signature of cemetery

18. Signature of burial

19. Signature of interment

20. Signature of record

21. Signature of certificate

22. Signature of death

23. Signature of burial

24. Signature of interment

25. Signature of record

BUREAU V. S.

FEB 21 1956

RECEIVED

EMORY, JUNE 24

1. Name of deceased
2. Sex
3. Race
4. Date of birth
5. Place of birth
6. Date of death
7. Place of death
8. Cause of death
9. Manner of death
10. Signature of physician
11. Signature of coroner
12. Signature of registrar
13. Signature of informant
14. Signature of witness
15. Signature of funeral director
16. Signature of undertaker
17. Signature of cemetery
18. Signature of burial
19. Signature of interment
20. Signature of record
21. Signature of certificate
22. Signature of death
23. Signature of burial
24. Signature of interment
25. Signature of record

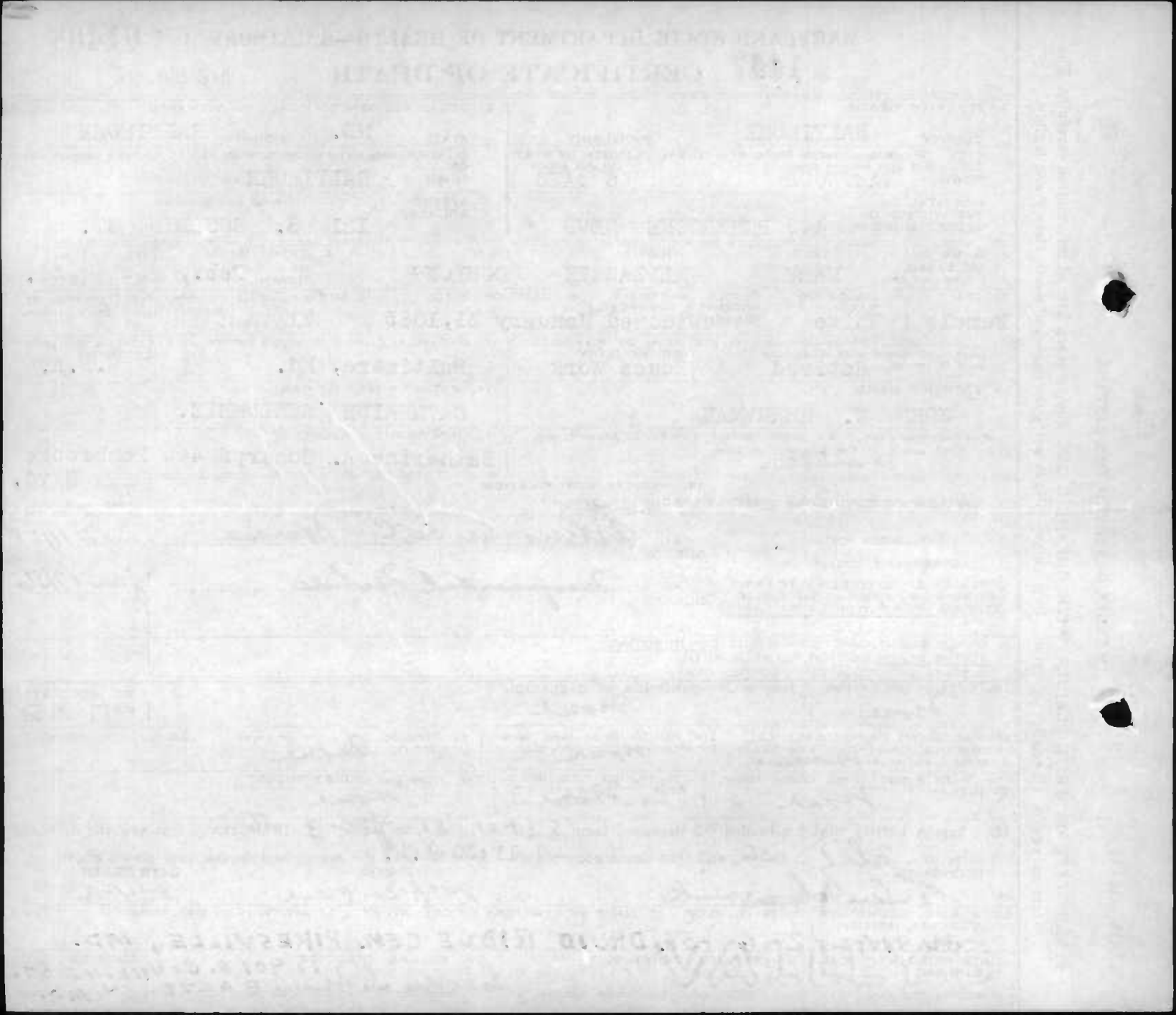
1447 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MD.		COUNTY BALTIMORE	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN EASTWOOD		LENGTH OF STAY (in this place) 6 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 445 PEMBROOKE BLVD				STREET ADDRESS (If rural give location) 121 S. BOULDIN ST.			
3. NAME OF DECEASED: (First) MARY (Middle) ELIZABETH (Last) DOULONG				4. DATE (Month) (Day) (Year) OF DEATH: Feb., 3, 1956.			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: January 31, 1885	9. AGE last birthday 71 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired		10B. KIND OF BUSINESS OR INDUSTRY: House Work		11. BIRTHPLACE (State or foreign country): Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: JOHN W. MERRYMAN				14. MOTHER'S MAIDEN NAME: CATHERINE STEINMETZ.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) None		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: Catherine A. Scharpf 445 Pembroke Blvd.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Arteriosclerosis, C.V. Disease						Spt 11/55	
ANTECEDENT CAUSE (S) (B) Myocardial Failure						Jan 17/56	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: None		19B. MAJOR FINDINGS OF OPERATION: None				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.) None		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State) None			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY None M.		21E. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work None		21F. HOW DID INJURY OCCUR? None			
22. I hereby certify that I attended the deceased from Spt 11, 1955 , to Feb 3, 1956 , that I last saw the deceased alive on Feb 1, 1956 , and that death occurred at 11:30 AM from the causes and on the date stated above.							
SIGNATURE S. G. Schumacher		M.D. 8424 E. + Ave		DATE SIGNED 7-4-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 2-6-56		NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEM.		LOCATION (City, town, or county) (State) PIKESVILLE, MD.	
DATE REC'D BY LOCAL REGISTRAR Feb 6, 1956		REGISTRAR'S SIGNATURE C. W. Hedrich		24. FUNERAL DIRECTOR Charles S. Giller		ADDRESS 901 S. CONKLING ST. BALTO., MD.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



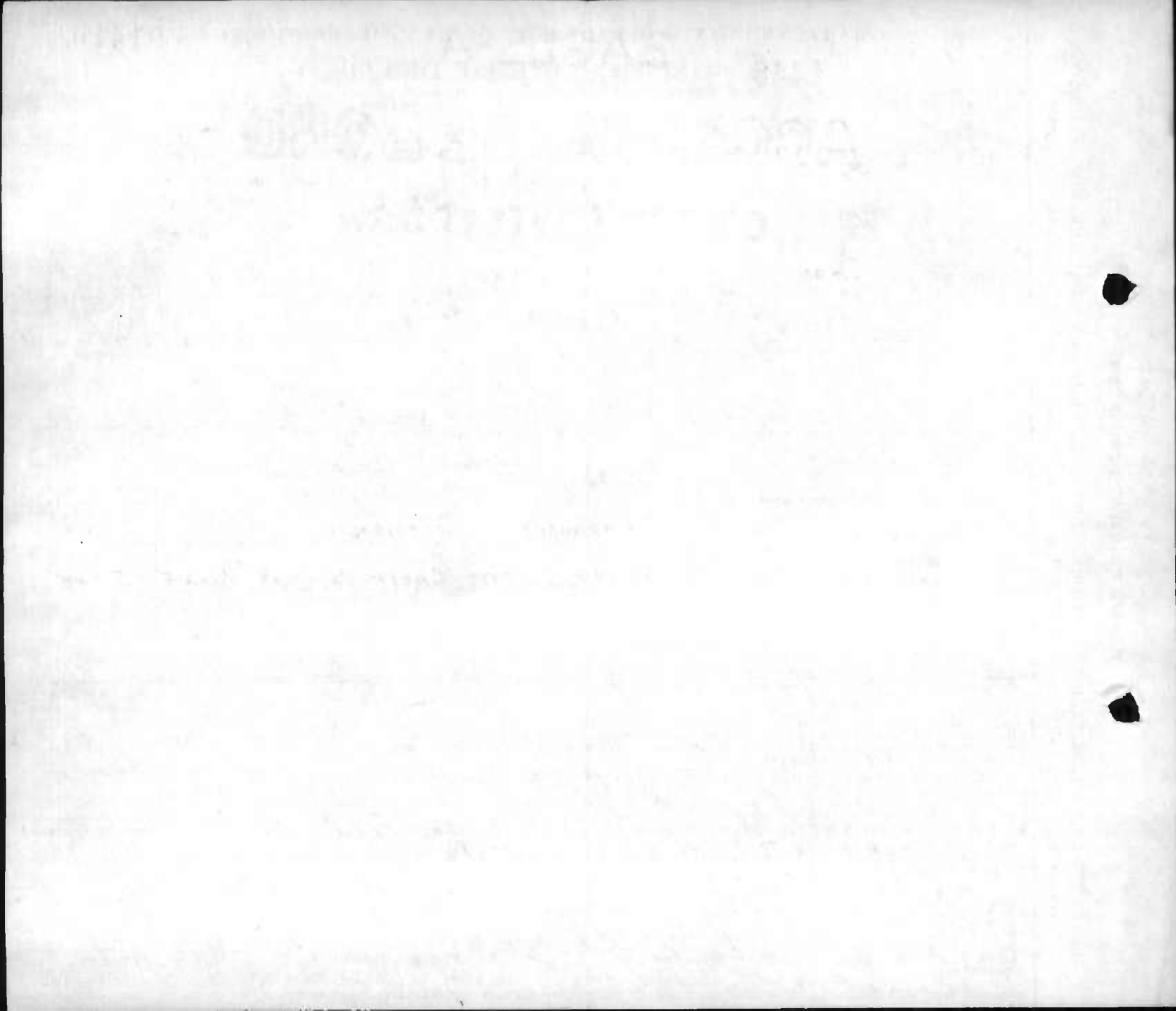
1448 CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Ind</i>	COUNTY <i>Bald</i>
CITY (If outside corporate limits, write RURAL or and give nearest town) <i>Hoodlawn</i>	LENGTH OF STAY (in this place) <i>16 years</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Hoodlawn</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>50</i>		STREET ADDRESS (If rural give location) <i>6712 Edmond Ave</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>JOHN</i>	(Middle) <i>C.</i>	(Last) <i>DYKE</i>	(Month) <i>Feb</i> (Day) <i>11</i> (Year) <i>1956</i>
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>Aug 16/1887</i>
9. AGE last birthday <i>68</i> yrs.		10. AGE last birthday UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Retired Steel Worker</i>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>Essex Co Virginia</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>John Dyke</i>		14. MOTHER'S MAIDEN NAME: <i>Margaret</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT & ADDRESS: <i>Edith P. Dyke 6712 Edmond Ave</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <i>CORONARY THROMBOSIS</i>			<i>1 HR.</i>
ANTECEDENT CAUSE (S) (B) <i>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</i>			<i>5 YRS.</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>DEC. 19, 1956</i> , to <i>FEB. 11, 1956</i> , that I last saw the deceased alive on <i>FEB. 11, 1956</i> , and that death occurred at <i>10:30 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Marrin Goldstein</i>		ADDRESS <i>M. D. 5334 Liberty Heights Ave.</i> DATE SIGNED <i>Feb. 12, 1956</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>Feb. 15/1956</i>	
NAME OF CEMETERY OR CREMATORY <i>Lorraine</i>		LOCATION (City, town, or county) (State) <i>Hoodlawn Ind</i>	
DATE REC'D BY LOCAL REGISTRAR <i>2-15-56</i>		REGISTRAR'S SIGNATURE <i>John H. Adams</i>	
24. FUNERAL DIRECTOR <i>Nancy P. Chinnock</i>		ADDRESS <i>4204 Ridgewood Ave</i>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

1384

CERTIFICATE OF DEATH

Reg. Dist. No.

01411

1. PLACE OF DEATH COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1925 Wareham Rd</u>		STREET ADDRESS <u>1925 Wareham Road</u>	
3. NAME OF DECEASED (Type or Print) <u>Helen</u>		4. DATE OF DEATH (Month) <u>Feb</u> (Day) <u>1</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Jan 1886</u>	
9. AGE last birthday <u>69</u> yrs.		10. AGE last birthday If under 1 year: Months <u>1</u> Days <u>1</u> If under 24 hrs: Hours <u>1</u> Min. <u>1</u>	
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Poland</u>	
13. FATHER'S NAME <u>George Konapka</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Skrochi</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>216-16-8437B</u>	
17. INFORMANT <u>Mrs Frances Rice</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1956, to 1956, that I last saw the deceased

alive on 2-1-56, 19....., and that death occurred at 1:30 PM m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR INTERMENT (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Interment</u>	<u>2-14-56</u>	<u>SACRED HEART OF MARY GERMAN HILL RD</u>	<u>Balt 22</u>	<u>2-3-56</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>2-3-56</u>	<u>Dr. DeLoach</u>	<u>John M. Weber</u>	<u>4015 C. Weber St</u>	

9 11.30

Dr Jack Collins
2 Kinder Road

Alameda 5-2295

1449 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO.</u> MARYLAND		STATE <u>MD.</u> COUNTY <u>BALTO.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>TOWSON 4</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>TOWSON 4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6 LINDEN TERRACE</u>		STREET ADDRESS (If rural give location) <u>6 Linden Terrace</u>		LENGTH OF STAY (in this place) <u>30 YRS</u>			
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>George</u> (Last) <u>Edel</u>				4. DATE OF DEATH: (Month) <u>2</u> (Day) <u>16</u> (Year) <u>1956</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>July 25, 1873</u>	
9. AGE last birthday: <u>82</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life even if retired: <u>Accountant</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Balto, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME: <u>Henry J. Edel</u>			
14. MOTHER'S MAIDEN NAME: <u>EVA AMERIN</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>			
16. SOCIAL SECURITY No.: <u>213-05-8766</u>				17. INFORMANT & ADDRESS: <u>Chas. H.B. Edel (son) 6 Linden Terr Towson 4, Md</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) <u>Coronary occlusion</u>						<u>12 hours</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Acute Pleurisy</u>							
(c)							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death. <u>Acute Pleurisy</u>							
19a. DATE OF OPERATION: <u>None</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 30</u> , 19 <u>56</u> , to <u>Feb 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 12</u> , 19 <u>56</u> , and that death occurred at <u>8:00 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>A.J. Chalfont M.D.</u>		(Degree or title)		ADDRESS <u>6210 York Rd Baltimore 4</u>		DATE SIGNED <u>Feb 16, 56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>Feb 18 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		LOCATION (City, town, or county) (State) <u>Balto Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 15 1956</u>		REGISTRAR'S SIGNATURE <u>Edmund</u>		24. FUNERAL DIRECTOR <u>H. Frankins & Sons</u>		ADDRESS <u>4905 York Rd</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MEMORANDUM

1063 2 pages

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

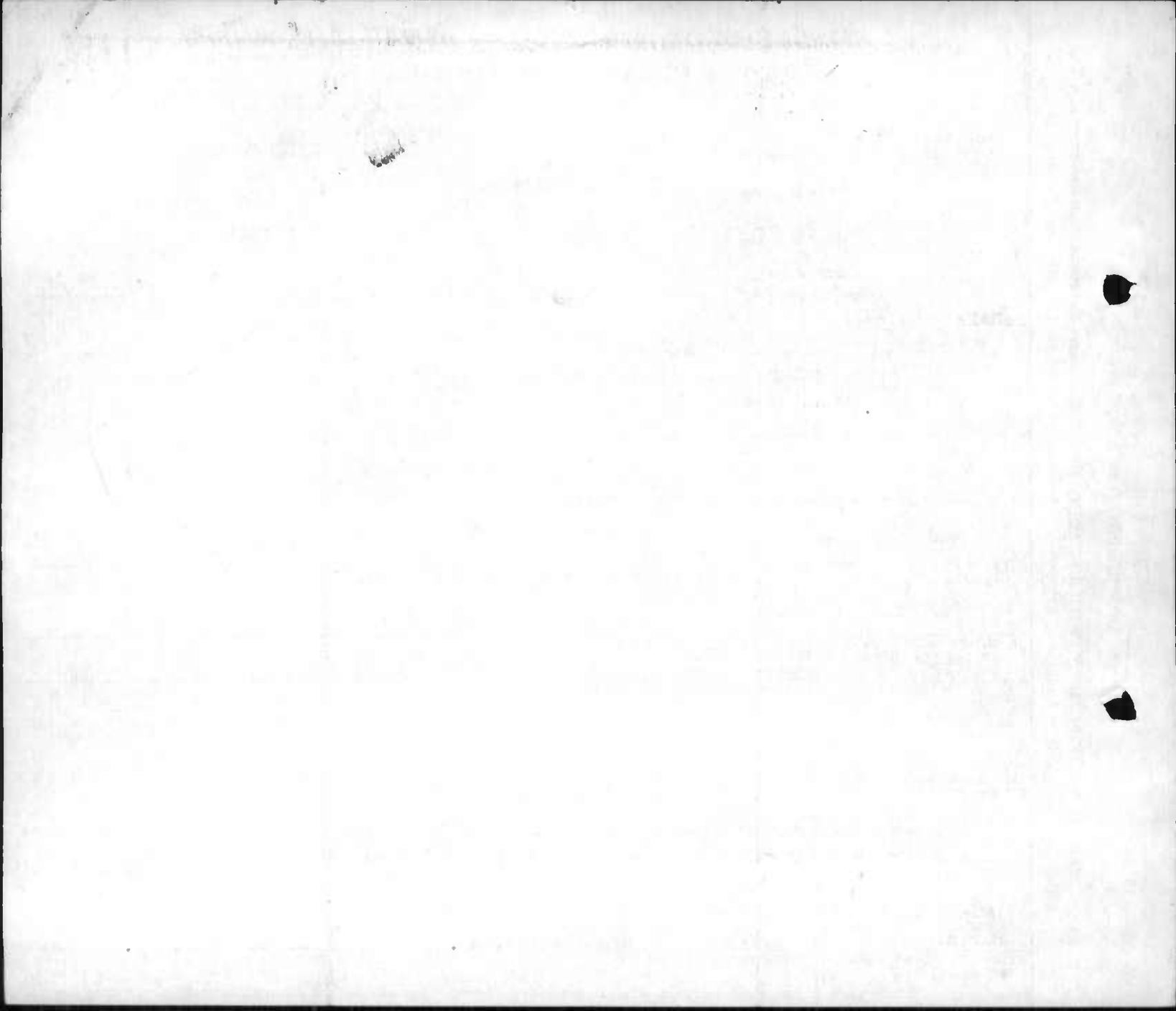
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01413

1450 CERTIFICATE OF DEATH

Reg. Dist. No. 30

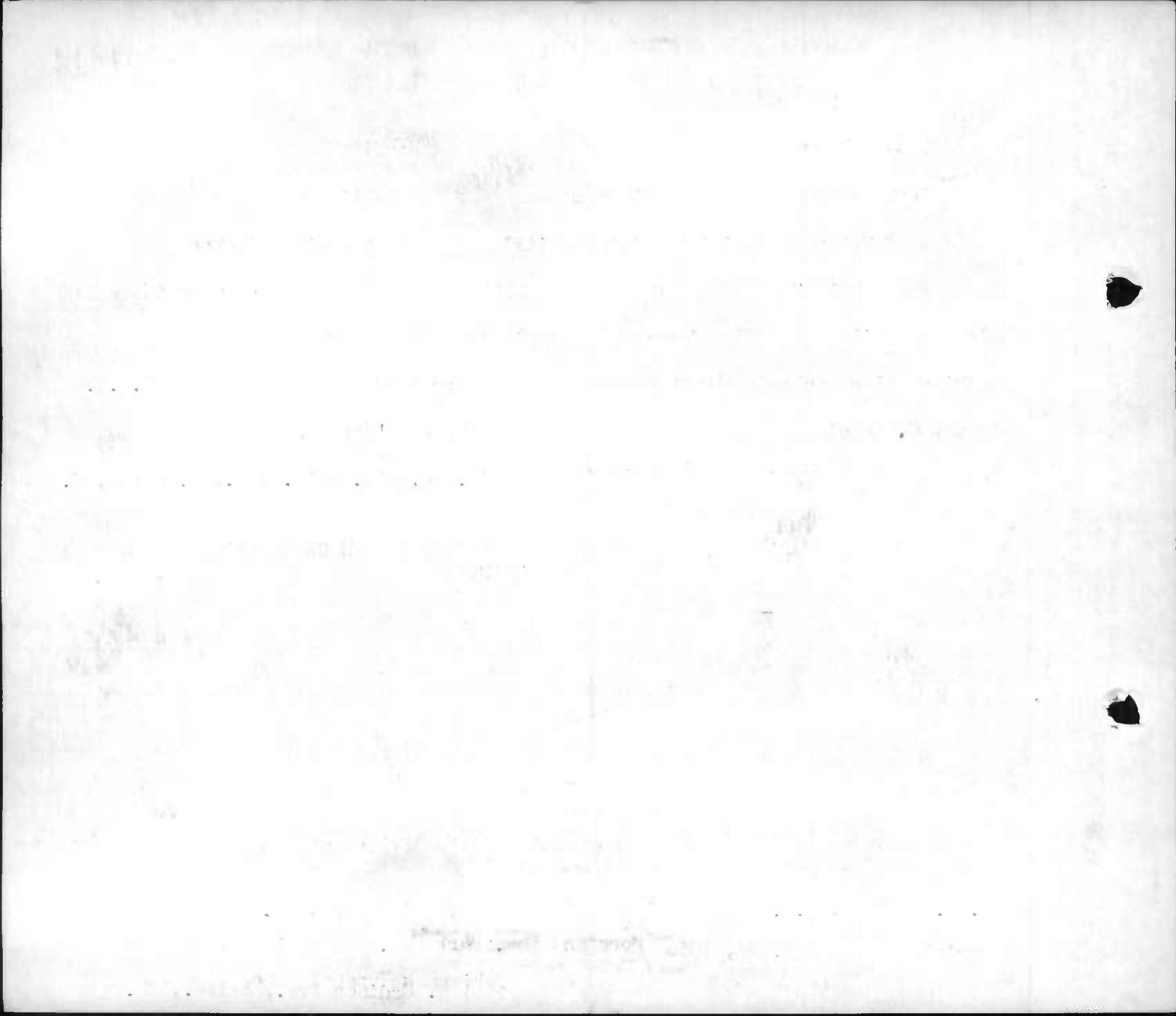
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>52 Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>1530 John Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Mae</u> <u>Mae</u> <u>Belle Elliott</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>February 6,</u> <u>19 56</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH: <u>12-13-1887</u>
9. AGE last birthday <u>68</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Demonstrator</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country): <u>Indiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Vinton F. Merryman</u>		14. MOTHER'S MAIDEN NAME: <u>Alice Diffenbaugh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <u>Rupture of heart</u>			
ANTECEDENT CAUSE (S) DUE TO			
(B) <u>Subacute myocardial infarction</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO			
(C) <u>Coronary arteriosclerosis</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bilateral Pyonephrosis</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>2</u>			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7</u> , 1953, to <u>2-5</u> , 1956, that I last saw the deceased alive on <u>2-5</u> , 1956, and that death occurred at <u>9:15PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Stella Wachler</u>		ADDRESS <u>Spring Grove State Hospital</u> <u>M. D. Catonsville 28, Maryland</u>	
DATE SIGNED <u>Feb 7, 1956</u>		DATE SIGNED <u>2-6-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/9/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Westminster, Conn.</u>		LOCATION (City, town, or county) (State) <u>Westminster, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 7, 1956</u>		REGISTRAR'S SIGNATURE <u>G. H. Hedrick</u>	
FUNERAL DIRECTOR <u>Wm. J. Lickner & Sons - Balt. 17 Ind.</u>		ADDRESS <u>Balt. 17 Ind.</u>	



1451 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
TOWN <u>Fort Howard</u>	<u>137 days</u>	TOWN <u>Baltimore</u>	<u>3401.4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>5062 Orville Avenue</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH	
<u>MELVIN C EMMEL</u>		<u>February 25 1956</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Divorced</u>	<u>12/12/13</u>
9. AGE last birthday		10. CITIZEN OF WHAT COUNTRY?	
<u>42 yrs.</u>		<u>U.S.A.</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		12. BIRTHPLACE (State or foreign country):	
<u>Refrigeration Mechanic</u>		<u>Maryland</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>August C. Emmel</u>		<u>Helen O'Hara</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
<u>Yes</u> <u>WWII</u>		<u>216-07-2498</u>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Clin. Rec. Vets. Admin. Hosp., Ft. Howard, Md.</u>		<p>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>IMMEDIATE CAUSE (A) <u>BRONCHOGENIC CARCINOMA WITH CEREBELLAR METASTASIS</u></p> <p>ANTECEDENT CAUSE (B) <u>METASTASIS</u></p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)</p> <p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</p>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>October 11, 1955</u> , to <u>February 25, 1956</u> , that I last saw the deceased <u>on February 25, 1956</u> , and that death occurred at <u>11:45 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>A. G. EDWARDS, M.D.</u>		ADDRESS <u>M. D. VAH, Fort Howard, Md.</u>	
DATE SIGNED <u>2/25/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. FUNERAL DIRECTOR	
<u>Burial</u>		<u>Schimmey Funeral Home</u>	
DATE THEREOF <u>Feb. 28, 1956</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
NAME OF CEMETERY OR CREMATORY <u>Moreland Mem. Park Cem.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>2-27-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	
		ADDRESS <u>2601 E. Madison Ave., Balto., Md.</u>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01415

1452 CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto.</u>		STATE <u>Md.</u>		COUNTY <u>Balto.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Parkton</u>		<u>Life</u>		TOWN <u>Parkton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Falls Rd.</u>				STREET ADDRESS (If rural give location) <u>Falls Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Clifton</u> (Middle) <u>Tansley</u> (Last) <u>Ensor</u>				(Month) <u>2</u> (Day) <u>8</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widower</u>	<u>Feb 22, 1875</u>	<u>80</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farmer</u>		<u>Farm owner</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Luke E Ensor</u>				<u>Laura Tansley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>				<u>Edward Harry Ensor Parkton Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
592x IMMEDIATE CAUSE (A) <u>Cardiac Failure, Pulmonary Hypostasis.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Senility</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <u>Chronic Nephritis, Chronic Prostatitis.</u>							
STATING UNDERLYING CAUSE LAST. TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>10 years</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 6, 1956</u> , to <u>Feb 8, 1956</u> , that I last saw the deceased alive on <u>Feb 8, 1956</u> , and that death occurred at <u>12 noon</u> , from the causes and on the date stated above.							
SIGNATURE <u>J. Cole Bowers</u>				M.D. <u>New Freedom, Pa.</u>		DATE SIGNED <u>Feb 8, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-11-56</u>		<u>Black Rock Cem</u>		<u>Butler Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>2-11-56</u>		<u>Mrs. Howard S. Marshall</u>		<u>J. Scott Brooks, Sparks, Md.</u>			

CERTIFICATE OF DEATH

Form 10-1-54

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. BIRTH DATE

6. BIRTH PLACE

7. MARRIAGE

8. OCCUPATION

9. CAUSE OF DEATH

10. PLACE OF DEATH

11. TIME OF DEATH

12. SIGNATURE

13. DATE

14. PLACE

15. SIGNATURE

16. DATE

17. PLACE

18. SIGNATURE

19. DATE

20. PLACE

21. SIGNATURE

22. DATE

23. PLACE

24. SIGNATURE

25. DATE

26. PLACE

27. SIGNATURE

28. DATE

29. PLACE

30. SIGNATURE

31. DATE

32. PLACE

33. SIGNATURE

34. DATE

35. PLACE

36. SIGNATURE

37. DATE

38. PLACE

39. SIGNATURE

40. DATE

41. PLACE

42. SIGNATURE

43. DATE

44. PLACE

45. SIGNATURE

46. DATE

BUREAU V. 2

FEB 14 1956

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1801416
1453 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY St. Mary's
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville	LENGTH OF STAY (in this place) 2yrs. 7mth. 29days.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 SPRING GROVE STATE HOSPITAL	STREET ADDRESS (If rural give location) Mechanicsville, Md.		
3. NAME OF DECEASED: (First) (Middle) (Last) Della Ferrell		4. DATE OF DEATH: (Month) (Day) (Year) Feb. 28 19 56	
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widow	8. DATE OF BIRTH: Oct. 1, ?
9. AGE last birthday 85 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife		10B. KIND OF BUSINESS OR INDUSTRY: --	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: John Herbert		14. MOTHER'S MAIDEN NAME: Rebecca	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) unknown		16. SOCIAL SECURITY NO. unknown	
17. INFORMANT & ADDRESS: Records of Spring Grove State Hospital			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) 422.1 Cardiac failure with myocardial involvement			
ANTECEDENT CAUSE (B) Arteriosclerotic cardiovascular disease			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-30, 1955 , to 2-28, 1956 , that I last saw the deceased alive on 2-28 , 19 56 , and that death occurred at 5:03pM , from the causes and on the date stated above.			
SIGNATURE Greta Wachler		DATE SIGNED 2-28-56	
ADDRESS SPRING GROVE STATE HOSP. Catonsville 28, Md.		M. D.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-2-56	
NAME OF CEMETERY OR CREMATORY St John's		LOCATION (City, town, or county) (State) Clinton, Md.	
DATE REC'D BY LOCAL REGISTRAR 3/5/56		REGISTRAR'S SIGNATURE V. E. Gandy	
24. FUNERAL DIRECTOR The Hunt Funeral Home		ADDRESS Waldorf, Md.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 51

MR 6 1956

RECEIVED

1454

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 32

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mount Washington</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Mount Washington, Md.</u>	
TOWN <u>Mount Washington</u>		TOWN <u>Mount Washington, Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Smith Avenue</u>	
3. NAME OF DECEASED (First) <u>CHARLES</u> (Middle) <u>EDWARD</u> (Last) <u>FIDLER</u>		4. DATE OF DEATH (Month) <u>FEBRUARY</u> (Day) <u>3</u> (Year) <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>August 9, 1941</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. AGE last birthday <u>14</u> yrs. If under 1 year: Months <u>14</u> Days <u>14</u> Hours <u>14</u> Mins. <u>14</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles Edward Fidler</u>		14. MOTHER'S MAIDEN NAME <u>Mildred Anna Sinclair</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Charles E. Fidler, Jr. Smith Ave.</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Inhalation of Fire & Generalized

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Complete Body Burns Entire(c) Clathing on Fire Death by Suffocation Sudden

INTERVAL BETWEEN ONSET AND DEATH

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) Home

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐HOW DID INJURY OCCUR? In trying to start a fire in iron coal stove in kitchen with some fluid which exploded, setting fire to kitchen.22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION OR REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb 5, 1956 Harvey A. NewellFrank H. Newell, Baltimore

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 7 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

1455 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01418

Item 21 Film G193 2-24-56 ams

Medical Examiner

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fullerton</u>				TOWN <u>Fullerton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 494 Fitch Ave.</u>				STREET ADDRESS (If rural give location) <u>Box 494 Fitch Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>William F. Fitch</u>				DEATH: <u>Feb. 9 1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>July 19, 1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Truck Farming</u>		11. BIRTHPLACE (State or foreign country): <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>William Fitch</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Hoeb</u>			
15. WAS DECEASED EVER IN U.S. ARMOED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>Mrs. Elizabeth Hefner-7723 Belair Rd</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Generalized Abdominal Cramping</u>						1 minute	
ANTECEDENT CAUSE (B) <u>injury - Accidental Death</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Rear of home</u>		21C. WHERE DID (City or town) (County) (State) <u>Fullerton Balto. Md.</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>unspecified M. 2-10-56</u>		21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Trapped beneath tractor he was driving when he evidently drove same into ditch and it overturned on him</u>			
22. I hereby certify that I attended the deceased from <u>2-10-56</u> to <u>2-10-56</u> , that I last saw the deceased alive on <u>2-10-56</u> and that death occurred at <u>8:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Jack Collins M.D. Deputy Medical Examiner</u>		ADDRESS <u>2 Kniskip</u>		DATE SIGNED <u>2-10-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-13-1956</u>		NAME OF CEMETERY OR CREMATORY <u>St. Joseph's</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 11-1956</u>		REGISTRAR'S SIGNATURE <u>Dr. J. B. Reynolds</u>		24. FUNERAL DIRECTOR <u>Carroll Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	

BUREAU V. S.

FEB 16 1956

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01419

1456 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>PARKVILLE</u>		<u>4 DAYS</u>		TOWN <u>PARKVILLE</u> (14) 75X-3			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>3022 WILLOUGHBY RD.</u>				<u>STENARTSTOWN, PA.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>LOUIS HENRY FITZELL</u>				<u>7-10-56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W.</u>	<u>WIDOWED</u>	<u>17 JUNE 1885</u>	<u>70</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>FARMER</u>		<u>TRUCK FARM</u>		<u>MD.</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>THOMAS R. FITZELL</u>				<u>REBECCA LOHMULLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>213-22-8505</u>		<u>L. MORGAN FITZELL - SEE #1</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
<u>cerebral Hemorrhage.</u>						<u>30 hours</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-9</u> , 19 <u>56</u> , to <u>2-10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-10</u> , 19 <u>56</u> , and that death occurred at <u>3:40P.</u> M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Harold H B Wins</u>				<u>8106 Harford Rd.</u>		<u>2-10-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>2-13-56</u>		<u>OAK LAWN</u>		<u>BALTO. CO. MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>FEB 14 1956</u>		<u>Dr. A. M. Bacon</u>		<u>Edith Ruth Buckley, Norfolk, N.Y.</u>			

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A156 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01420

1457 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u> OR TOWN <u>3 mos</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balto</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u> OR TOWN <u>3801 W. Harrison Ave</u> STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) <u>William D. Fleagle</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>Feb 19 1956</u> (Month) (Day) (Year)	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Aug 24 1889</u>
9. AGE last birthday <u>66</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Painter</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Theodore H. Fleagle</u>		14. MOTHER'S MAIDEN NAME <u>Margaret O. Williams</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>218-05-9035</u>	
17. INFORMANT & ADDRESS <u>Mrs Edwin Lewis 2719 Maple Ave</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
162X IMMEDIATE CAUSE (A) <u>Bronchogenic carcinoma with</u>			
ANTECEDENT CAUSE(S) DUE TO <u>generalized metastases</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u></u>			
STATING UNDERLYING CAUSE LAST. (C) <u></u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 1, 1956</u> , to <u>Feb 19, 1956</u> , that I last saw the deceased alive on <u>Feb 19, 1956</u> , and that death occurred at <u>11:38 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>William D. Fleagle</u>		DATE SIGNED <u>2-20-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/22/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		LOCATION (City, town, or county) <u>Balto</u>	
24. REC'D BY REGISTRAR <u>Dr. A. M. Brown</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byers</u>	
ADDRESS <u>5005 E. Epton</u>		CITY <u>Balto</u> STATE <u>Md</u>	
DATE <u>FEB 24 1956</u>			

1458 CERTIFICATE OF DEATH

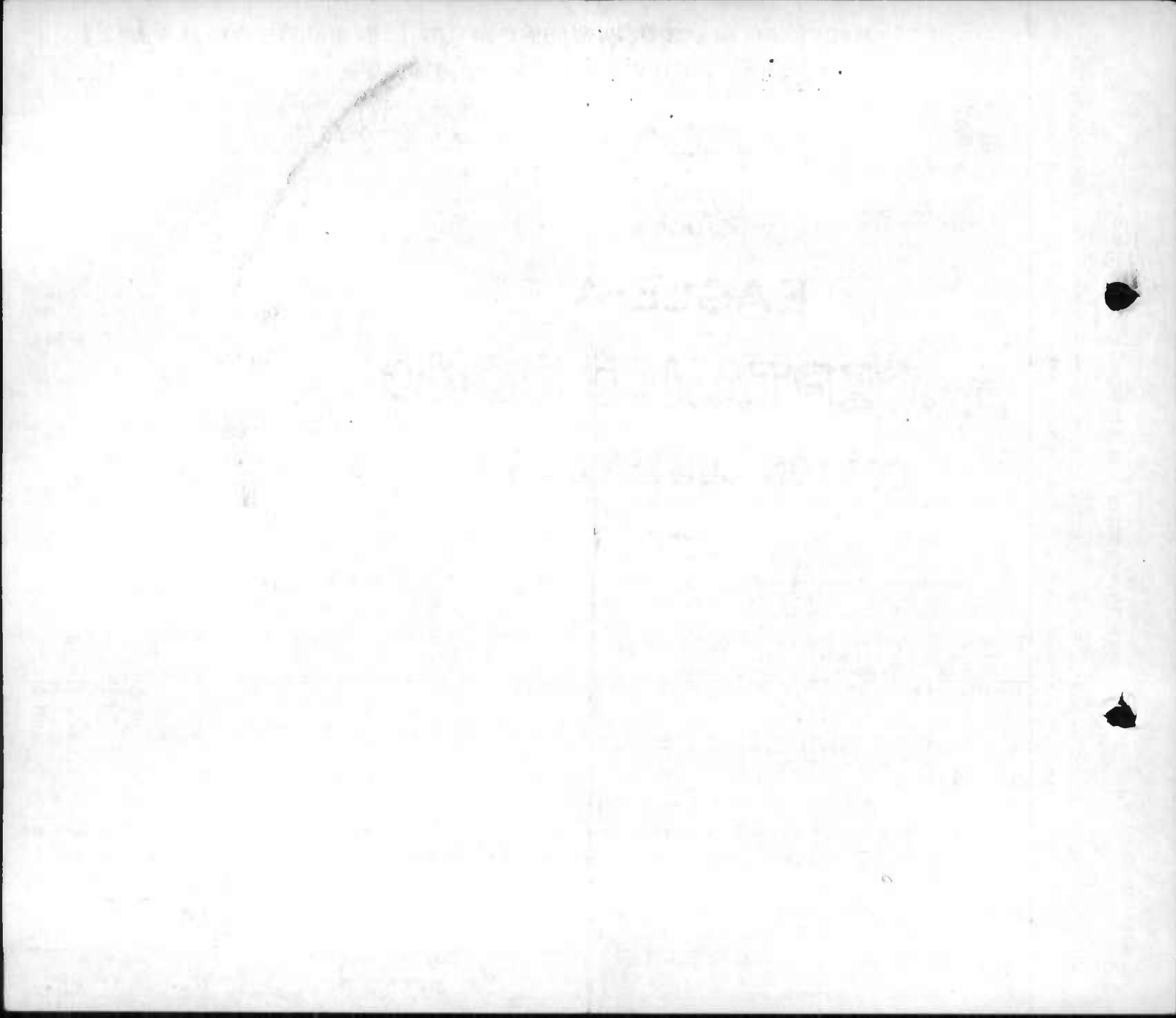
Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL) OR TOWN <u>Catonsville</u>	LENGTH OF STAY (in this place) <u>2yrs 9mos 2days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>2621 N. Calvert Street</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Lillian</u>	(Middle) <u>F.</u>	(Last) <u>Foard</u>	
(Type or Print)		OF DEATH <u>February 14, 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>11-1879</u>
9. AGE last birthday <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John B. Gallaher</u>		14. MOTHER'S MAIDEN NAME: <u>Julia E. McAdee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Arteriosclerotic cardiovascular disease</u>			
ANTECEDENT CAUSE (S) DUE TO (B) <u>Generalized arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Senility</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>7-</u> , 19 <u>53</u> to <u>2-14-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-14-</u> , 19 <u>56</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Stella Woodrider</u>		DATE SIGNED <u>2-14-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>2/17/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Parkville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 15, 1956</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook, Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1459

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
X TOWN <u>Fort Howard</u>	<u>1 Day</u>	STREET ADDRESS (If rural give location) <u>4335 Falls Road</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS <u>4335 Falls Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>HARRY JAMES FRANK</u>		OF DEATH: <u>February 24 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>3/16/92</u>
9. AGE last birthday <u>63</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Senior Investigator B&O Railroad</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Elias Theodore Frank</u>		14. MOTHER'S MAIDEN NAME: <u>Welthy A.A. Thayer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW-I</u>		16. SOCIAL SECURITY NO. <u>705-09-1127</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>CARCINOMA OF PROSTATE WITH METASTASIS</u>		UNKNOWN
DUE TO <u>TO RIBS AND VERTEBRA</u>		
ANTECEDENT CAUSE (S)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(B) DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

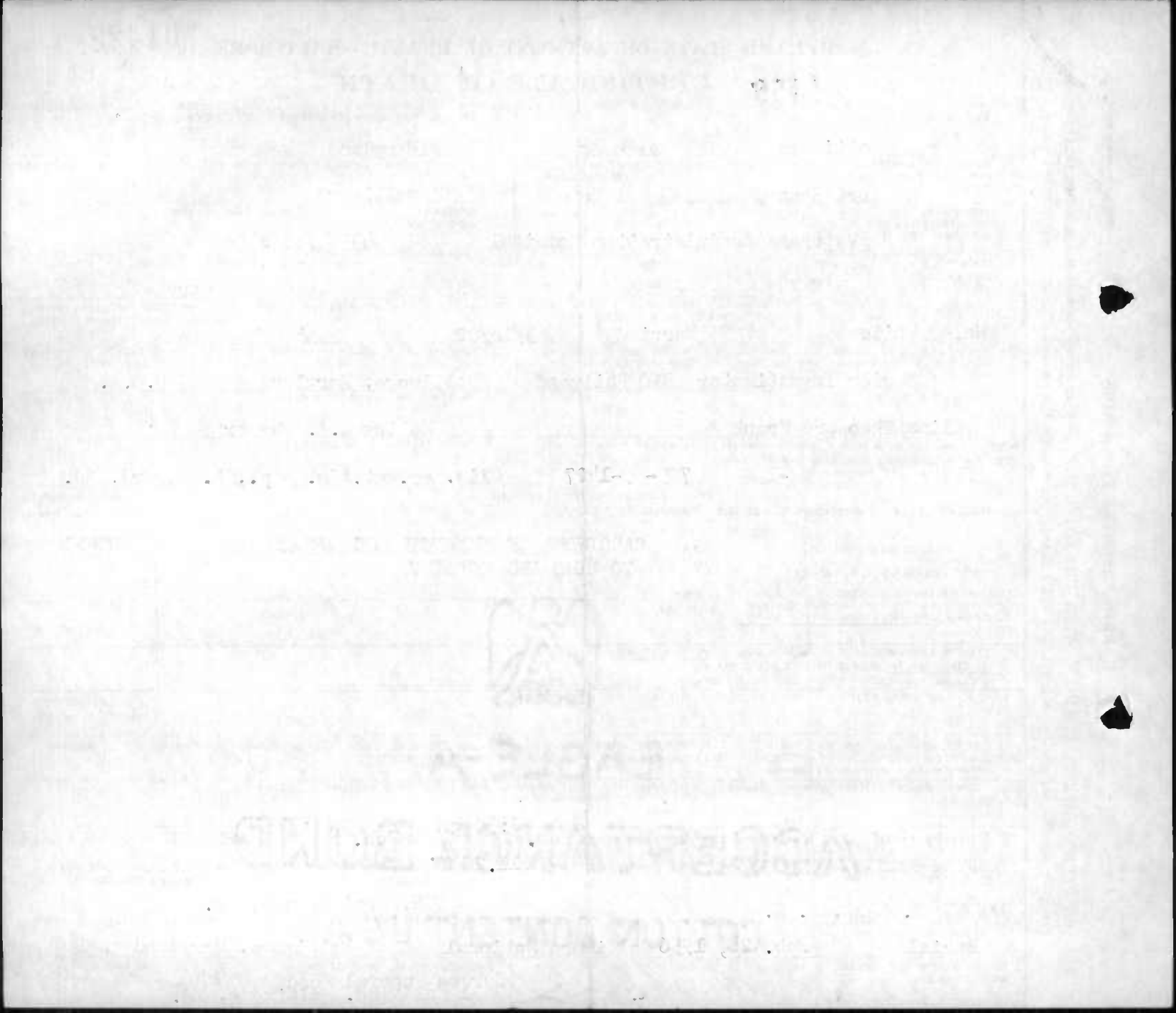
19A. DATE OF OPERATION: <u>2</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 23, 1956, to Feb. 24, 1956, and that death occurred at 11:20 M, from the causes and on the date stated above.	
SIGNATURE <u>Donald D. Mark</u>	DATE SIGNED <u>Feb. 28, 1956</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 28, 1956</u>	24. FUNERAL DIRECTOR <u>Burgee Funeral Home</u>
REGISTRAR'S SIGNATURE <u>[Signature]</u>	ADDRESS <u>3631 Falls Rd. Baltimore, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01423

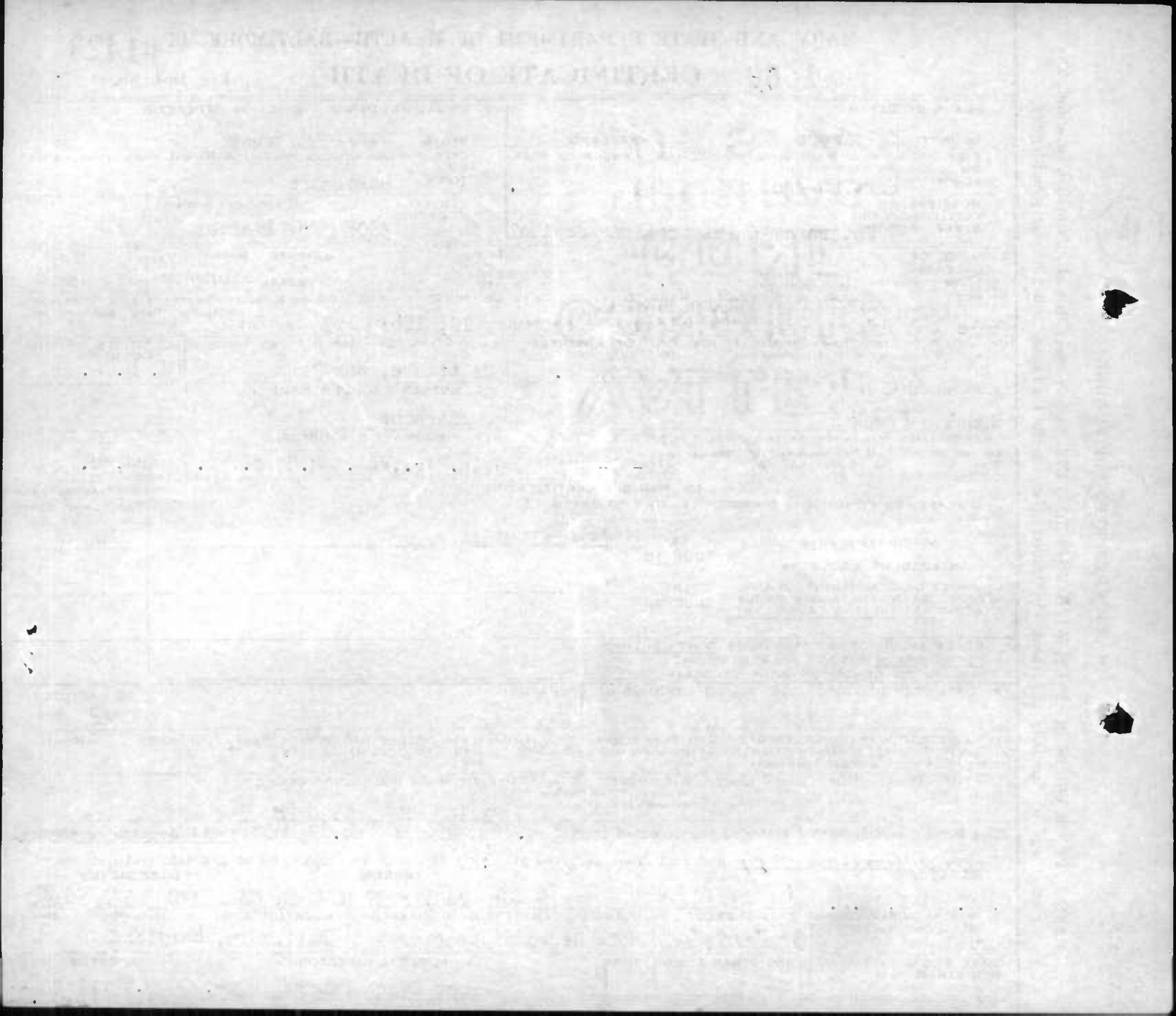
1460 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Fort Howard</u>		<u>6 Hours 30M.</u>		TOWN <u>Baltimore</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Veterans Administration Hospital</u>				<u>3608 Mary Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>LAWRENCE J. FRANKEL</u>				<u>February 29 19 56</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>February 19, 1887</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Hat Blocker</u>				<u>Mens Hats, Inc.</u>		<u>Baltimore, Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Rudolph Frankel</u>				<u>Julia Nohe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>Yes</u> <u>WW I</u>				<u>214-03-0888</u>		<u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>LOBAR PNEUMONIA</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?			
<u>VA</u> <u>M.</u>		<u>While at work</u>		<u>12:50 PM 6:20 PM</u>			
22. I hereby certify that I attended the deceased from <u>Feb. 29, 1956</u> , to <u>Feb. 29, 1956</u> , that I last saw the deceased <u>alive on 19 1956</u> , and that death occurred at <u>6:20 M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Denore</u>				DATE SIGNED <u>3/1/56</u>			
D. D. MARK, M.D.				M. D. VAH, FORT HOWARD, MARYLAND			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-5-1956</u>		<u>Holy Redeemer Cemetery</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-5-56</u>		<u>[Signature]</u>		<u>Jerome Cvach Funeral Home</u>		<u>900 N. Chester St. Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01424

1461 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>8 Days</u>		TOWN <u>5535 Windsor Mill Road, Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>5535 Windsor Mill Road</u>			
3. NAME OF DECEASED (Type or Print) <u>FRANK F. FULENWIDER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>February 28 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 29, 1898</u>	9. AGE last birthday <u>57</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Payroll Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Aircraft</u>		11. BIRTHPLACE (State or foreign country) <u>Henrietta, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>William Fulenwider</u>				14. MOTHER'S MAIDEN NAME <u>Clara Nelson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>212-12-4369</u>		17. INFORMANT & ADDRESS <u>Clin. Rec. Vet. Adm. Hospital, Ft. Howard Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
163X IMMEDIATE CAUSE (A) <u>BRONCHOGENIC CARCINOMA, RIGHT LUNG AND MEDIASTINUM</u>				INTERVAL BETWEEN ONSET AND DEATH <u>UNKNOWN</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that <u>VA</u> attended the deceased from <u>Feb. 20</u> , 19 <u>56</u> , to <u>Feb. 28</u> , 19 <u>56</u> , <u>that his law the deceased</u> and that death occurred at <u>5:45A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey</u>				DATE SIGNED <u>2-28-56</u>			
FRANCIS G. DICKEY, M.D., Chief, Medical Service VAH, FORT HOWARD, MARYLAND							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-2-56</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>MAR 5 1956</u>		REGISTRAR'S SIGNATURE <u>Thurston L. Parker</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc.</u>		ADDRESS <u>6009 Harford Rd. Balto. Md.</u>	

1951 CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased (Print or type)

2. Sex (M or F)

3. Date of birth (Month, day, year)

4. Place of birth (City, State, Country)

5. Usual residence (Street, City, State, Country)

6. Date of death (Month, day, year)

7. Time of death (Hour, minute)

8. Cause of death (List all causes, beginning with the immediate cause)

9. Manner of death (Natural, Accidental, Suicide, Homicide, Undetermined)

10. Signature of physician (Print name, then sign)

11. Signature of coroner (Print name, then sign)

12. Signature of registrar (Print name, then sign)

13. Signature of informant (Print name, then sign)

14. Signature of witness (Print name, then sign)

15. Signature of registrar (Print name, then sign)

16. Signature of registrar (Print name, then sign)

17. Signature of registrar (Print name, then sign)

18. Signature of registrar (Print name, then sign)

19. Signature of registrar (Print name, then sign)

20. Signature of registrar (Print name, then sign)

BUREAU V. S.

MAR 6 1956

RECEIVED

MAR 6 1956

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1462 CERTIFICATE OF DEATH

01425

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cockeysville</u>		<u>Yrs.</u>		TOWN <u>Cockeysville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Balto. County Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u>		(Middle)		(Last) <u>Gibson</u>		(Month) (Day) (Year)	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>Feb. 11 1956</u>	
9. AGE last birthday <u>60?</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Levi Burton</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Tager</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT & ADDRESS <u>Balto. Co. Home Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						3 hrs.	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) <u> </u>							
STATING UNDERLYING CAUSE LAST, DUE TO (C) <u> </u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes mellitus</u>						5 years.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1956</u> , to <u>Feb 1956</u> , that I last saw the deceased alive on <u>Feb 11 1956</u> , and that death occurred at <u>12:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Elizabeth B. Shumill</u>				ADDRESS (Street, city, town, state) <u>Cockeysville Md.</u>		DATE SIGNED <u>2/11/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>2/11/56</u>		NAME OF CEMETERY OR CREMATORY <u>University Medical Bldg. Lombard & Green Sts</u>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u> </u>		REGISTRAR'S SIGNATURE <u>W. J. Whitehead</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>L. Scott Brooks</u>		ADDRESS <u>Sparks, Md</u>	

CERTIFICATE OF DEATH

Form 10-1-55

1. PLACE OF DEATH

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF BIRTH

10. OCCUPATION

11. MARITAL STATUS

12. EDUCATION

13. RELIGION

14. SIGNATURE OF DECEASED

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF REGISTRAR

17. PLACE OF BIRTH

18. OCCUPATION

19. MARITAL STATUS

20. EDUCATION

21. RELIGION

22. SIGNATURE OF DECEASED

23. SIGNATURE OF WITNESSES

24. SIGNATURE OF REGISTRAR

25. PLACE OF BIRTH

26. OCCUPATION

27. MARITAL STATUS

28. EDUCATION

29. RELIGION

30. SIGNATURE OF DECEASED

31. SIGNATURE OF WITNESSES

32. SIGNATURE OF REGISTRAR

33. PLACE OF BIRTH

34. OCCUPATION

35. MARITAL STATUS

36. EDUCATION

37. RELIGION

38. SIGNATURE OF DECEASED

39. SIGNATURE OF WITNESSES

40. SIGNATURE OF REGISTRAR

41. PLACE OF BIRTH

42. OCCUPATION

43. MARITAL STATUS

44. EDUCATION

45. RELIGION

46. SIGNATURE OF DECEASED

47. SIGNATURE OF WITNESSES

48. SIGNATURE OF REGISTRAR

BUREAU V. S.

FEB 14 1956

RECEIVED

RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1392

CERTIFICATE OF DEATH

01426

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 57 Halethorpe, Md.				c. LENGTH OF STAY IN 1b 30			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5704 First Ave.				d. STREET ADDRESS 5704 First Ave.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First George Middle Gillis Last Gillis				4. DATE OF DEATH Month Feb. Day 23 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH March 20, 1880	
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Retired		11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gilbert Gillis		14. MOTHER'S MAIDEN NAME Jane Campe					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-09-8546		17. INFORMANT George W. Gillis 5601 Ashbourne Road			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of prostate gland 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Retention of urine - E capsules and (c) prostatitis				INTERVAL BETWEEN ONSET AND DEATH 4 1/2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 23 , 19 56 , to Feb 23 , 19 56 , that I last saw the deceased alive on Feb 23rd , 19 56 , and that death occurred at 12:45 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Frederic V. Bester				ADDRESS (Street, city or town, state) 1014 Fremas Ave - Balto 27-79456			
DATE SIGNED Feb 27 1956							
PHYSICIAN'S NAME (Type) Howard H. Hubbard 4107 Wilkens Ave.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 27, 1956		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard H. Hubbard				ADDRESS 4107 Wilkens Ave.		24a. REC'D BY REGISTRAR Feb 27 1956	
24b. REGISTRAR'S SIGNATURE Dr. Geo. S. Kueffer							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

BUREAU V. S.

FEB 27 1956

RECEIVED

1463

CERTIFICATE OF DEATH

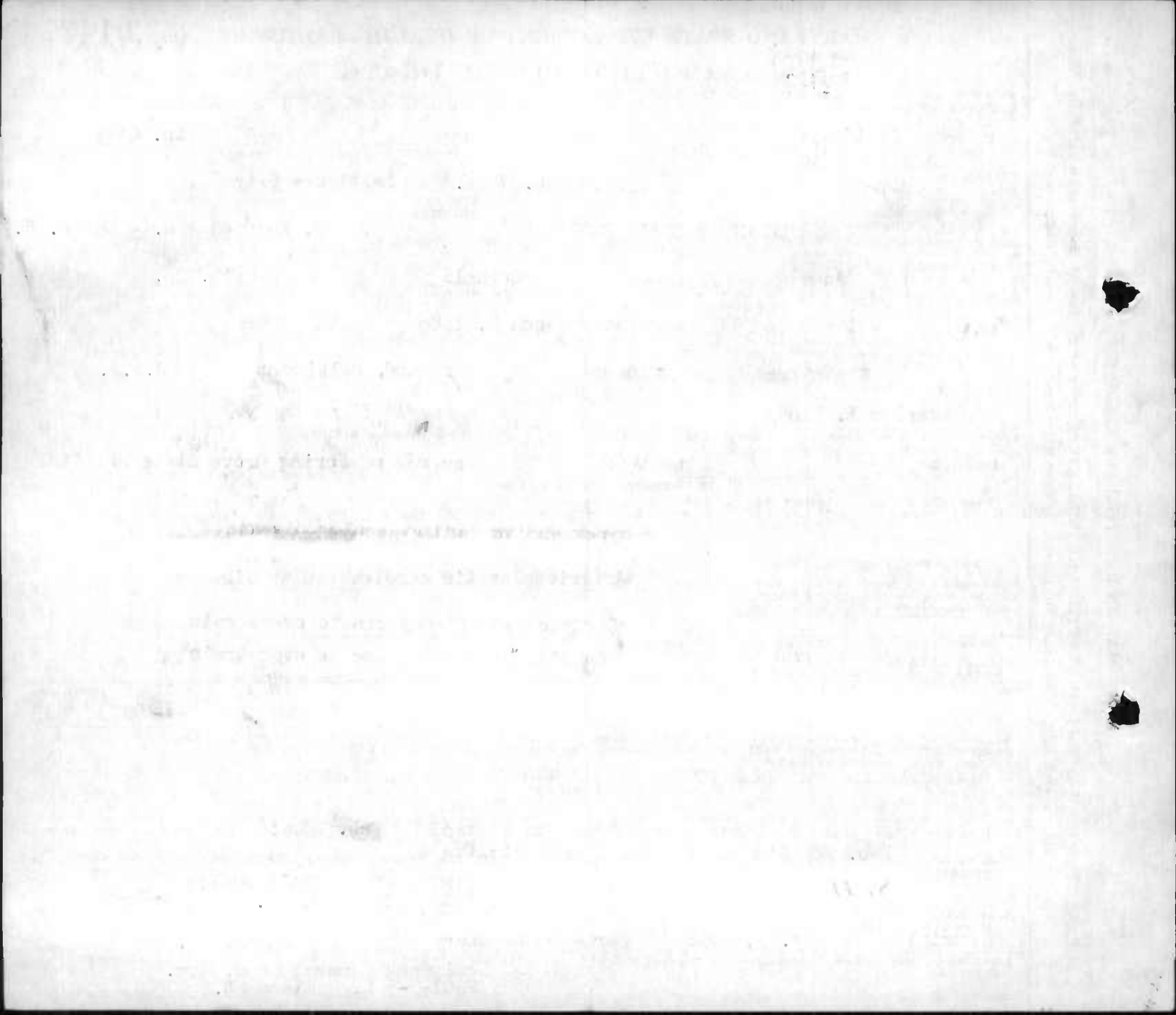
Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE		COUNTY Balto. City	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville		LENGTH OF STAY (in this place) 3yrs. 8mths. 27days.		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3401-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 SPRING GROVE STATE HOSPITAL		STREET ADDRESS (If rural give location) 730 N. Kenwood Ave. - Balto. 5.					
3. NAME OF DECEASED: (First) (Middle) (Last) Anna Handy Gosnell				4. DATE (Month) (Day) (Year) OF DEATH: Feb. 28, 1956			
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: March 9, 1886	9. AGE last birthday 69 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): seamstress		10B. KIND OF BUSINESS OR INDUSTRY: unknown		11. BIRTHPLACE (State or foreign country): Maryland, Baltimore		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Charles E. Handy				14. MOTHER'S MAIDEN NAME: Maggie Eiman Handy			
15. WAS DECEASED EVER IN U.S. ARMED FORCE? (Yes, no, or unk.) unknown		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) unknown		17. INFORMANT & ADDRESS: Records of Spring Grove State Hospital			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Hypertensive cardiovascular disease							
ANTECEDENT CAUSE (S) Arteriosclerotic cardiovascular disease							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Cardiac hypertrophy due to overstrain							
(C) Cardiac dilitation due to overstrain							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July , 19 53 to Feb. 28 , 19 56 , that I last saw the deceased alive on Feb. 28 , 19 56 , and that death occurred at 11:40 PM , from the causes and on the date stated above.							
SIGNATURE Sheila Wachler		M. D. SPRING GROVE STATE HOSP: Catonsville 28, Md.		DATE SIGNED 2-28-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Mar. 3, 1956		NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR 3-7-56		REGISTRAR'S SIGNATURE AW Hedrick		24. FUNERAL DIRECTOR Schimunek Funeral Home, Inc.		ADDRESS 2601-3-5 E. Madison St.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01428

1464

CERTIFICATE OF DEATH

Reg. Dist. No. ~~428~~

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Baltimore</i>		STATE <i>Md.</i>		COUNTY <i>Baltimore</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Phoenix</i>		LENGTH OF STAY (in this place) <i>life</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Phoenix</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Old York Rd</i>		STREET ADDRESS (If rural give location) <i>Old York Rd.</i>					
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <i>Magdalena Lintz Graefe</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>2-13-1956</i>			
5. SEX <i>female</i>	6. COLOR OR RACE <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>married</i>	8. DATE OF BIRTH <i>8-8-1878</i>	9. AGE last birthday <i>77</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>home</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>George Lintz</i>				14. MOTHER'S MAIDEN NAME <i>Elizabeth Waltz</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no</i>				16. SOCIAL SECURITY NO. _____		17. INFORMANT & ADDRESS <i>Fred E. Graefe, Phoenix, Md.</i>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
170X IMMEDIATE CAUSE (A) <i>Carcinoma of Breast</i>						<i>2 yrs</i>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C) _____							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Coronary Occlusion</i>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) _____ (County) _____ (State) _____			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) _____		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR? _____			
22. I hereby certify that I attended the deceased from <i>Feb-14-56</i> , 19 <i>56</i> , to <i>Feb-14-56</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Feb-14-56</i> , 19 <i>56</i> , and that death occurred at <i>2:00</i> P.M., from the causes and on the date stated above.							
SIGNATURE <i>Walter M. Hammitt</i>		DATE THEREOF <i>2-16-56</i>		NAME OF CEMETERY OR CREMATORY <i>Evangelical Reform</i>		DATE SIGNED <i>Feb-15-56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		LOCATION (City, town, or county) <i>Hackensack, Balto. Co. Md.</i>		ADDRESS (Street, city, town, state) _____			
24. REC'D BY REGISTRAR <i>Feb-15-56</i>		REGISTRAR'S SIGNATURE <i>Walter M. Hammitt</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Scott Brooks</i>		ADDRESS <i>Sparks, Md.</i>	
DATE <i>Feb 17-56</i> <i>M. Elizabeth Gorsuch</i>							

MARYLAND STATE DEPARTMENT OF HEALTH

1465

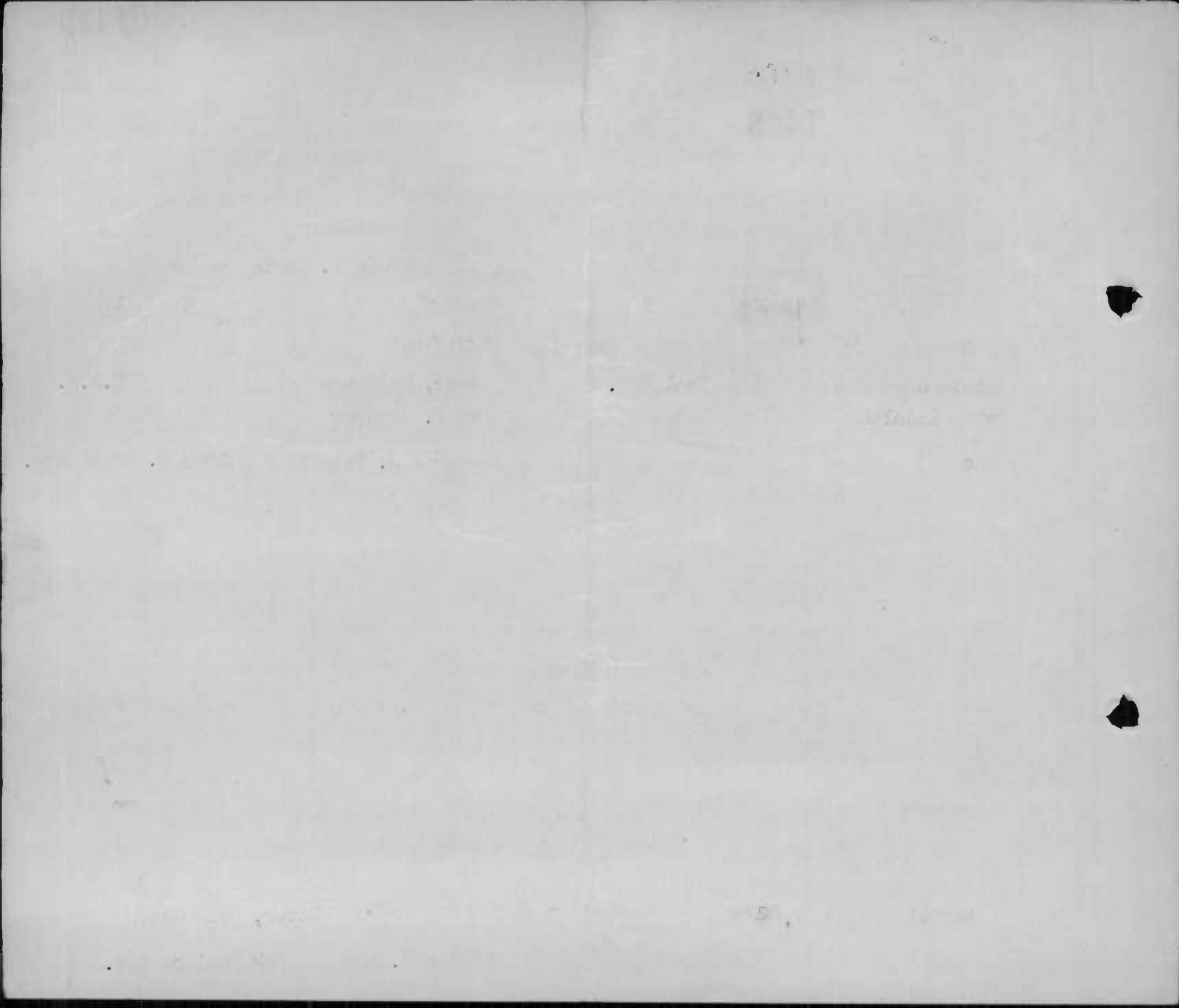
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Black & Decker Co. - Joppa Rd.</u>		STREET ADDRESS (If rural, give location) <u>1909 W. North Avenue</u>	
3. NAME OF DECEASED (First) <u>FRANK</u> (Middle) <u>L</u> (Last) <u>GRANGER</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>17</u> (Year) <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>12/21/1895</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Maintenance Man</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tool Mfg.</u>	9. AGE last birthday <u>60</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Dover, Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Windolph</u>		14. MOTHER'S MAIDEN NAME <u>Eva C. Granger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Margaret G. Valentine</u> <u>1909 W. North Ave.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Coronary Thrombosis</u> Antecedent cause(s) (b) <u>Disease or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c)			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <u>Charles F. O'Donnell M.D.</u> (Degree or title)		ADDRESS <u>7501 York Rd. Towson #4</u>	
DATE SIGNED <u>2/17/56</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2/22/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Whatcoat - Silver Lake Dr.</u>		LOCATION (City, town, or county) <u>Dover, Delaware</u> (State)	
DATE RECD BY LOCAL REG. <u>Feb 20, 1956</u>		REGISTERAR'S SIGNATURE <u>C. W. Hedrick</u>	
24. FUNERAL DIRECTOR <u>Charles R. Law</u>		ADDRESS <u>802 Madison Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1466 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MD.	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN CATONSVILLE	LENGTH OF STAY (in this place) 5 WKS.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS HOUSE IN THE PINES NURSING HOME.	STREET ADDRESS (If rural give location) 1012 S. ELLWOOD AVE.		
3. NAME OF DECEASED: (First) (Middle) (Last) JOHN HERMAN GRESS		4. DATE (Month) (Day) (Year) OF DEATH: FEB. 16, 1956.	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH: MAY 13, 1876
9. AGE last birthday 79 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10B. KIND OF BUSINESS OR INDUSTRY: STAND. OIL CO.	
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: ? GRESS.		14. MOTHER'S MAIDEN NAME: UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO.		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT & ADDRESS:			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Broncho-Pneumonia			10 da.
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Chronic Hypertensive Cardio-Vascular Disease			10 yr. (?)
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 1-20, 1956 , to 2-16, 1956 , that I last saw the deceased alive on 2-16, 1956 , and that death occurred at 2:47 P.M. from the causes and on the date stated above.			
SIGNATURE William K. Gallagher		ADDRESS M. D. Catonsville-28, Md. DATE SIGNED 2-18-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	DATE THEREOF 2-20-56	NAME OF CEMETERY OR CREMATORY SACRED HEART CEM.	LOCATION (City, town, or county) (State) 7401 GERMAN HILL RD., MD.
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR Charles S. Guler ADDRESS 901 S. CONKLING ST. BALTO., MD.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. William Gallagher
6209 Frederick Ave

1467

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>SARRETT</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>MT. WILSON</u>		<u>3 months</u>		TOWN <u>OAKLAND</u>		<u>11X-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>02 MT. WILSON ST. Hospital</u>				STREET ADDRESS (If rural give location) <u>RD #2 Box 309</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Lucie ALICE GRIFFITH</u>				<u>2 19 56</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 MRS.	
<u>F</u>	<u>W</u>	<u>MARRIED</u>	<u>10.22.1884</u>	<u>71</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Waynsville, W. VA.</u>	
13. FATHER'S NAME: <u>Alphonso Taylor</u>				14. MOTHER'S MAIDEN NAME: <u>Molly Good.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. Social Security No. <u>NONE</u>		17. INFORMANT & ADDRESS:	

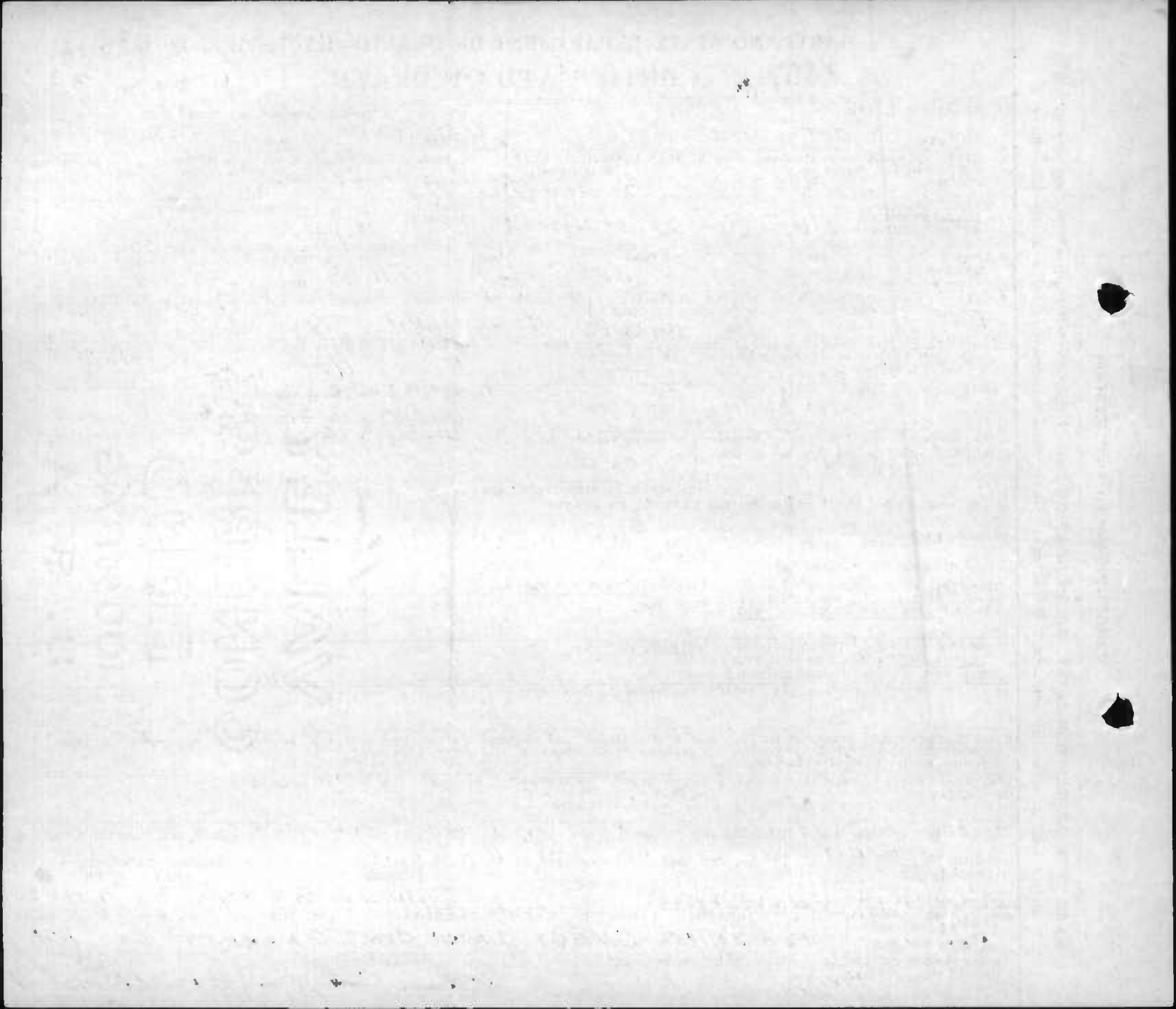
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Far advanced pulmonary tuberculosis</u>		
ANTECEDENT CAUSE (B) <u>Diabetes</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>260X</u>		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov. 8, 1955</u> , to <u>Feb. 19, 1956</u> , that I last saw the deceased alive on <u>Feb. 19, 1956</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.					
SIGNATURE <u>William Newman</u>		M. D. <u>MT. WILSON STATE Hosp.</u>		DATE SIGNED <u>Feb. 19, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>REMOVAL</u>		DATE THEREOF <u>FEB. 20, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>GNEGY CHURCH CEM.</u>	
LOCATION (City, town, or county) <u>GARRETT CO. Md.</u>					
DATE REC'D BY LOCAL REGISTRAR <u>Feb 20, 1956</u>		REGISTRAR'S SIGNATURE <u>G. W. Hedrick</u>		24. FUNERAL DIRECTOR ADDRESS <u>William Cook, Jr. 1217 St. Paul St.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01432
1468 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL OR and give nearest town) 523 TOWN Catonsville	LENGTH OF STAY (in this place) 6 months	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 02x-2 Annapolis	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hospital		STREET ADDRESS (If rural give location) County Home	
3. NAME OF DECEASED: (First) (Middle) (Last) Sally Franklin Hall		4. DATE (Month) (Day) (Year) OF DEATH: February 23, 19 56	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: 10-1-1879
9. AGE last birthday 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: R. T. Connor		14. MOTHER'S MAIDEN NAME: Elizabeth Franklin	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. Unknown	
17. INFORMANT & ADDRESS: Records Spring Grove State Hospital			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) 450.0 Generalized arteriosclerosis			Years
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B)			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8-23- , 19 55 to 2-23- , 19 56 , that I last saw the deceased alive on 2-23- , 19 56 , and that death occurred at 10:45 A. , from the causes and on the date stated above.			
SIGNATURE G. Wachler		ADDRESS Spring Grove State Hospital M. D. 2-23-56 DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	
Burial in Wood		2-24-56	
NAME OF CEMETERY Univ. of Md. Med. School		CITY AND TOWN, OR RURAL DISTRICT (State) Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR FEB 27 1956		REGISTRAR'S SIGNATURE J. C. Barry	
24. FUNERAL DIRECTOR		ADDRESS	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

89

174

71 3/4

154 cm

BUREAU OF
BUREAU OF

MAR 28 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01433

1385

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH: COUNTY BALTIMORE MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK LENGTH OF STAY (in this place) 20 YEARS
TOWN DUNDALK MD.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 225 MAPLE AVE.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY Beth
CITY (If outside corporate limits, write RURAL and give nearest town) DUNDALK MD.
TOWN DUNDALK MD.
STREET ADDRESS (If rural, give location) 225 MAPLE AVE.

3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)
WOODIE ROBERT HALL.

4. DATE OF DEATH (Month) (Day) (Year)
2 - 4 - 1956

5. SEX Male 6. COLOR OR RACE White 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married 8. DATE OF BIRTH 5-26-1896 9. AGE last birthday 59 yrs. If under 1 year Months Days If under 24 hrs. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN 10b. KIND OF BUSINESS OR INDUSTRY (Specify) BETHELHEM STEEL 11. BIRTHPLACE (State or foreign country) ALBERMAL COUNTY. 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JOHN HALL 14. MOTHER'S MAIDEN NAME PEARL WOOD.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY No. 218-10-6505 17. INFORMANT AND ADDRESS PEARL HALL 225 MAPLE AVE - 22

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Occlusion INTERVAL BETWEEN ONSET AND DEATH 6 weeks

Antecedent cause(s) (b) Arteriosclerotic Heart Disease 4 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
SUICIDE HOMICIDE INJURY

TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at Work ☐ Not While At work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 1, 1955, to Feb 4, 1956, that I last saw the deceased

alive on Feb 4, 1956, and that death occurred at 7 a.m., from the causes and on the date stated above.

SIGNATURE E. R. Evans (Degree or title) M.D. ADDRESS 1 Liberty Parkway DATE SIGNED Feb 4, 1956

23. BURIAL, CREMATION REMOVAL (Specify) DATE THEREOF 27-1956 NAME OF CEMETERY OR CREMATORY PRIZE HILL CEMETERY VA. LOCATION (City, town, or county) (State) BOONESVILLE VIRGINIA

DATE REC'D BY LOCAL REG. FEB 5 - 1956 REGISTRAR'S SIGNATURE H. E. T. Williams 24. FUNERAL DIRECTOR Walter Fabian ADDRESS 1001 A Dundalk Ave - Balt. 24 Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 8 1956
BUREAU V. S.

1469 CERTIFICATE OF DEATH

Reg. Dist. No. 44

I. PLACE OF DEATH:

COUNTY

Baltimore 19

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN

Spawcross Pt.

LENGTH OF STAY (in this place)

63 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

710 E. St.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

STREET ADDRESS

m (If rural, give location)
1.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

ANTON.

A.

HALVORSEN.

4. DATE

(Month)

(Day)

(Year)

OF

DEATH:

FEB.

7.

19

56.

5. SEX:

6. COLOR OR RACE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

male - white

white

married Jan 10. 1862

94 yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Rigger

10b. KIND OF BUSINESS OR INDUSTRY:

Steel mill

11. BIRTHPLACE (State or foreign country):

Norway

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Unknown

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

NO

16. SOCIAL SECURITY No.:

212-16.5655

17. INFORMANT & ADDRESS:

Lillian Halvorsen

address as in # 1.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

Cerebral Hemorrhage + hemiplegia

Hypertensive cardiovascular disease

atherosclerosis.

INTERVAL BETWEEN ONSET AND DEATH

2 days ago

20 yrs.

20 yrs.

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

prior Cerebral hemorrhage + hemiplegia

18 mo.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while M. work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 22, 1955 to Feb 7, 1956 that I last saw the deceased alive on Feb 7, 1956, and that death occurred at 8:30 P.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE)

ADDRESS

DATE SIGNED

Lillian N. Halvorsen, M.D.

6908 North Pt. Rd. Balto. 19-Md.

2/7/56.

23. BURIAL, CREMATION OR OTHER (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

BURIAL

2-10-56

MORRELAND MEM. PARK

BALTO. CO., Md.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb. 9/56

Lawson L. Larkins

Walt Burke Brady, Hurdock, Md.

44.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

FEB 10 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information-carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

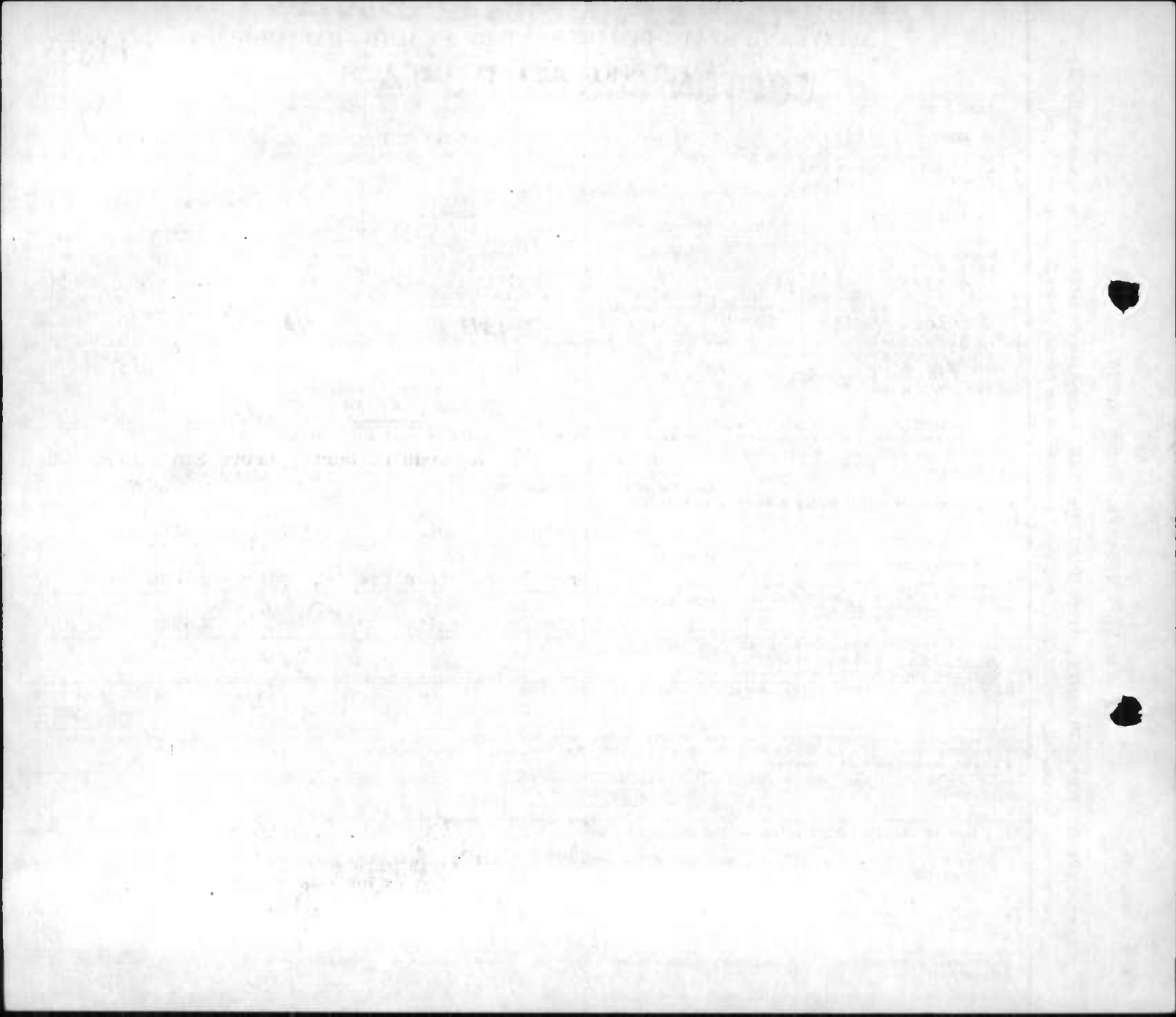
Items 8, 9, Film 92 2-21-56 et

1470

CERTIFICATE OF DEATH

Reg. Dist. No. 01435

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 TOWN Catonsville</u>	LENGTH OF STAY (in this place) <u>2mths. 21 dys.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 SPRINGGROVE STATE HOSP.</u>	STREET ADDRESS (If rural give location) <u>9131 Avondale Rd. - Parkville 14, Md.</u>		
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Lillie</u>	(Middle) <u>A</u>	(Last) <u>Hamilton</u>	(Month) <u>Feb.</u> (Day) <u>9,</u> (Year) <u>19 56</u>
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>1-29-1881</u>
9. AGE last birthday: <u>75</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housekeeper</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John A. Harb PLICE</u>		14. MOTHER'S MAIDEN NAME: <u>ANNA ELISA GORDON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>unknown</u>		16. SOCIAL SECURITY NO.: <u>unknown</u>	
17. INFORMANT & ADDRESS: <u>Records of Spring Grove State Hospital</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>260X Hypertensive arteriosclerotic heart disease</u>			
ANTECEDENT CAUSE (S) (B) <u>General arteriosclerosis, hypertension</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes, obesity</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>53</u> to <u>Feb.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 9,</u> 19 <u>56</u> , and that death occurred at <u>12:00M</u> , from the causes and on the date stated above.			
SIGNATURE <u>L. Glyne Williams</u>		DATE SIGNED <u>2/9/56</u>	
ADDRESS <u>SPRING GROVE STATE HOSP.</u>		M. D. <u>Catonsville 28 Md</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-11-56</u>	
NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 10, 1956</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Chas F Evans + Son 8802 Harford Rd.</u>	



01436

MARYLAND STATE DEPARTMENT OF HEALTH

1471 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 43

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md.</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overleg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overleg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5 Councilman Ave</u>		STREET ADDRESS (If rural, give location) <u>5 Councilman Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Martha</u>	(Middle) <u>H.</u>	(Last) <u>Hanson</u>
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Jan 6 1890</u>
9. AGE last birthday <u>66</u> yrs.		4. DATE OF DEATH <u>Feb 16</u> 19 <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Menomonee Wis.</u>		12. CITIZEN OF WHAT Country? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August Klatt</u>		14. MOTHER'S MAIDEN NAME <u>Helenetta ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Herbert A. Hanson 5 Councilman</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause

(a) Cerebral Hemorrhage

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

5 hrs.

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Joseph Chalieu Dep. Med. Ex. Balt 22

2-11-56

23. BURIAL, CREMATION OR REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Feb 16, 1956

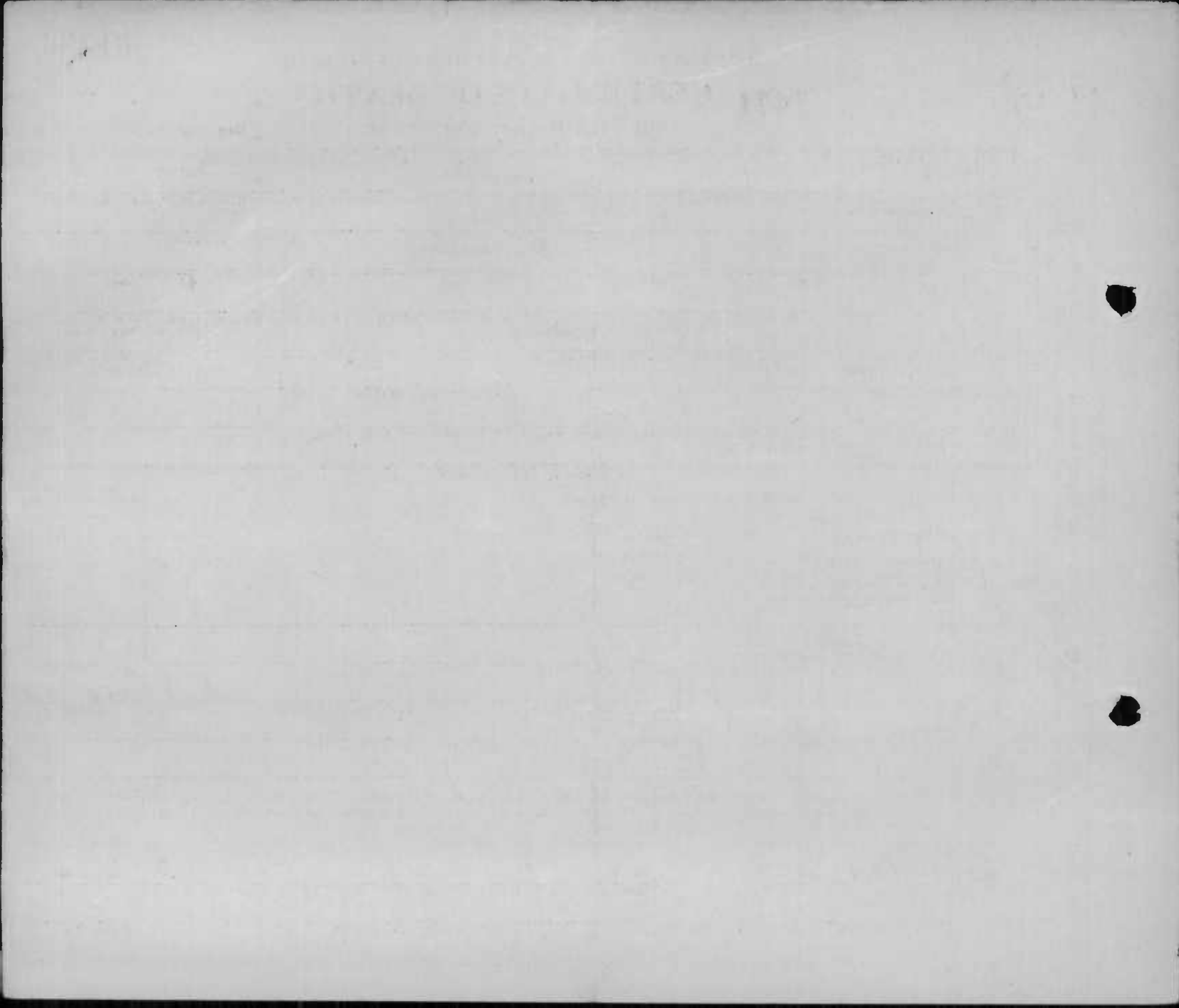
A. W. Hedrich

Slippel Bro.

7110 BELAIR RD.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



1472 CERTIFICATE OF DEATH

Reg. Dist. No. 44

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort Howard</u>	LENGTH OF STAY (in this place) <u>15 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore 22</u>	X
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>7236 Sollers Point Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>WILLIAM (NMI) HARPER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>February 10 19 56</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>11/3/98</u>
9. AGE last birthday: <u>57</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Machinist</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Machine Shop</u>	
11. BIRTHPLACE (State or foreign country): <u>Everson, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John E. Harper</u>		14. MOTHER'S MAIDEN NAME: <u>Mary O'Donahue</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>Yes</u> (If Yes, give war or dates of service) <u>WWI</u>		16. SOCIAL SECURITY NO. <u>218-28-0739</u>	
17. INFORMANT & ADDRESS: <u>Clin. Red., Vet. Adm. Hosp., Ft. Howard, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC HEART DISEASE</u>		UNKNOWN
DUE TO		
ANTECEDENT CAUSE (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>January 26 1956</u> , to <u>February 10 1956</u> , that I last saw the deceased <u>alive on 1956</u> , and that death occurred at <u>9:05 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>John J. Kennedy</u>		ADDRESS <u>M. D. VAH, Fort Howard, Md.</u>	
DATE SIGNED <u>2/10/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>2-14-56</u>	NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
DATE RECD BY LOCAL REGISTRAR <u>Feb. 14, 1956</u>	REGISTRAR'S SIGNATURE <u>Dawson L. Zarkov</u>	ADDRESS <u>Walter Brooks Bradley Funeral Home, Inc. 700 Willow Spring Rd., Balto. 22, Md.</u>	

RECEIVED
FEB 16 1956
BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1473

CERTIFICATE OF DEATH

01438

Reg. Dist. No. 39

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Md</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Monkton</u>	
CITY OR TOWN <u>Monkton</u>		LENGTH OF STAY (in this place) <u>8 yrs</u>		STREET ADDRESS (If rural give location) <u>Monkton Rd</u>		STREET ADDRESS <u>Monkton Rd</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Monkton Rd</u>				HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Monkton Rd</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Grayson</u> (Middle) <u>Harris</u> (Last) <u>Harris</u>				(Month) <u>February</u> (Day) <u>24</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 22 1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Henry Harris</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Cromwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Wife - Estelle Harris</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Arterio sclerotic Cardio-vascular disease over 8 yrs</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>February 19 1956</u> , to <u>February 24 1956</u> , that I last saw the deceased alive on <u>24 Feb 1956</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Halston T. Kees</u>				DATE SIGNED <u>24 Feb. 1956</u>			
M.D. <u>Cocheyville Md</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb 28-56</u>		NAME OF CEMETERY OR CREMATORY <u>Fairview Colored</u>		LOCATION (City, town, or county) (State) <u>Forest Hill, Md</u>	
24. REC'D BY REGISTRAR <u>MAR 2 1956</u>		REGISTRAR'S SIGNATURE <u>Mrs. Eliza Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Marion Skutz</u>		ADDRESS <u>Forest Hill, Md</u>	

CERTIFICATE OF DEATH

Form 100-100-100

1. Name of deceased (Print or type name)

2. Sex (Male or Female)

3. Date of birth (Month, day, year)

4. Place of birth (City, State, Country)

5. Date of death (Month, day, year)

6. Place of death (City, State, Country)

7. Cause of death (List all causes, beginning with the immediate cause)

8. Manner of death (Natural, Accidental, Suicide, Homicide, Undetermined)

9. Signature of physician (Print name and sign)

10. Signature of registrar (Print name and sign)

11. Signature of medical examiner (Print name and sign)

12. Signature of coroner (Print name and sign)

13. Signature of funeral director (Print name and sign)

14. Signature of family member (Print name and sign)

15. Signature of other (Print name and sign)

16. Signature of other (Print name and sign)

17. Signature of other (Print name and sign)

18. Signature of other (Print name and sign)

19. Signature of other (Print name and sign)

20. Signature of other (Print name and sign)

21. Signature of other (Print name and sign)

22. Signature of other (Print name and sign)

23. Signature of other (Print name and sign)

24. Signature of other (Print name and sign)

25. Signature of other (Print name and sign)

26. Signature of other (Print name and sign)

27. Signature of other (Print name and sign)

28. Signature of other (Print name and sign)

29. Signature of other (Print name and sign)

30. Signature of other (Print name and sign)

BUREAU V. S.

MAR 2 1956

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Handwritten notes and signatures at the bottom of the form, including names like "Foster H. H. H." and "M. H. H."

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
1474 FOR MEDICAL EXAMINERS

01439

Reg. Dist. No.

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Oliver Beach</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Oliver Beach</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>Rt. 14 Box 112</u>	
3. NAME OF DECEASED (First) <u>GEORGE</u> (Middle) <u>BOWEN</u> (Last) <u>HAUF</u>	4. DATE OF DEATH (Month) <u>2</u> (Day) <u>17</u> (Year) <u>1956</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3-16-1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Builder</u>	9. AGE last birthday <u>62</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Albert Hauf</u>		14. MOTHER'S MAIDEN NAME <u>Nelen Bower</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>17-09-10000</u>	
17. INFORMANT AND ADDRESS <u>Florence Hauf (Same)</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary Occlusion</u>		
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. PLACE (Home, farm, factory, street, or office bldg., etc.) <u>INJURY</u> (CITY OR TOWN) (COUNTY) (STATE)		
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u> INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

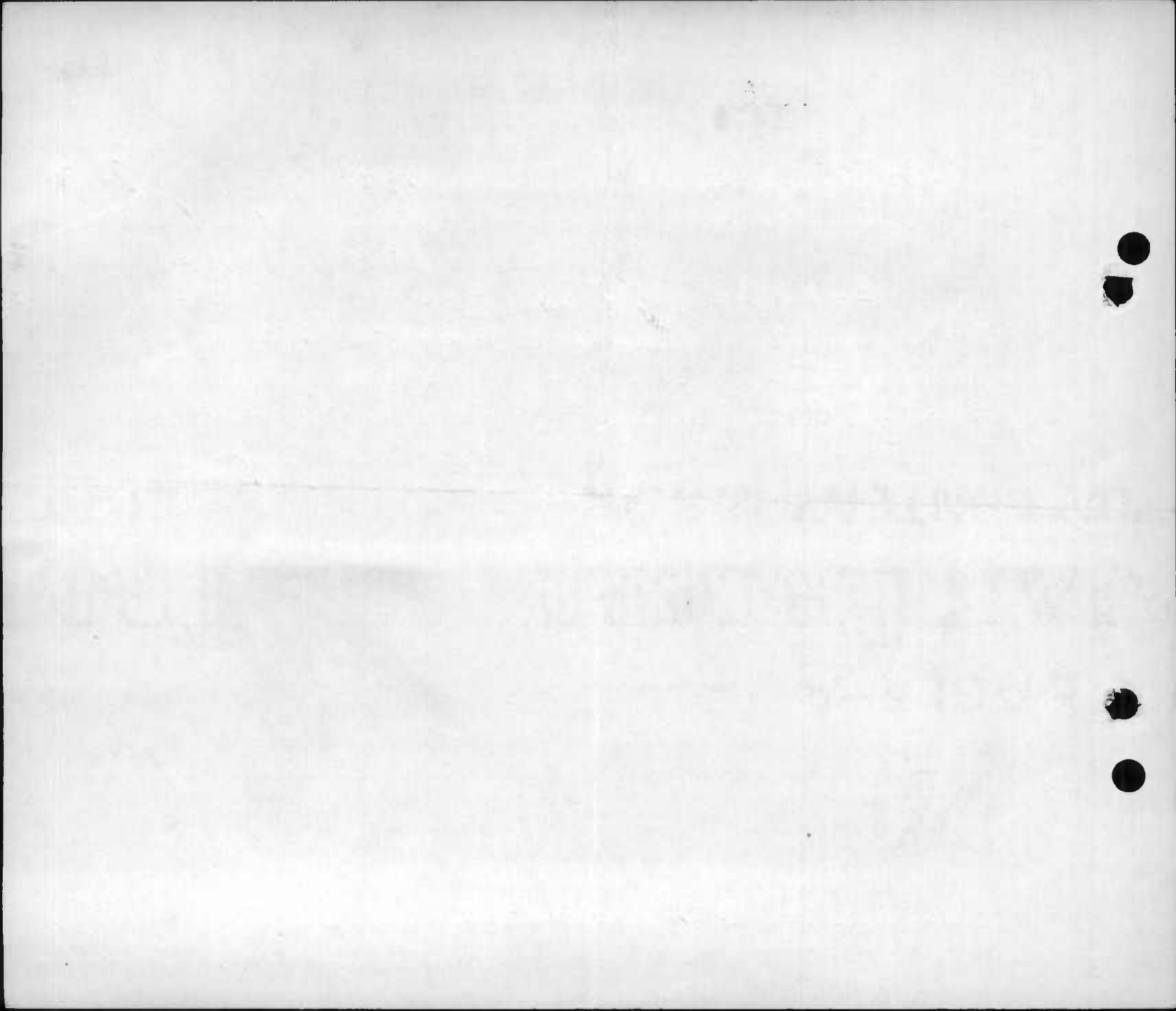
ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>2-21-56</u>	NAME OF CEMETERY OR CREMATORY <u>Balto. National</u>	LOCATION (City, town, or county) <u>Balto.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>Feb 20, 1956</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrich</u>	24. FUNERAL DIRECTOR <u>John G. Connelly</u>	ADDRESS <u>Essex Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1475 CERTIFICATE OF DEATH

01440

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		STATE Maryland		COUNTY Baltimore			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Parkville				TOWN Parkville			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 8117 Bon Air Road				STREET ADDRESS (If rural give location) 8117 Bon Air Road			
3. NAME OF DECEASED (Type or Print) Mrs. Ada Violet Heberling				4. DATE OF DEATH (Month) February 15, (Day) 19 (Year) 56			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH June 10, 1880	9. AGE last birthday 75 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Clearfield County, Penna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Smith				14. MOTHER'S MAIDEN NAME Jennie			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Thelma Gail Brungard, 8117 Bon Air			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) Myocarditis & degeneration				Coronary Thrombosis		6 Mos.	
ANTECEDENT CAUSE(S) DUE TO (B) Arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Aug 1955, to Feb 1956, that I last saw the deceased alive on Feb 14, 1956, and that death occurred at 9:00 P.M. from the causes and on the date stated above.							
SIGNATURE Frank D. Karik Jr.		M.D.		ADDRESS (Street, city, town, state) 9005 Harford Rd		DATE SIGNED 2/16/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 18, 1956		NAME OF CEMETERY OR CREMATORY Hill Crest Cemetery		LOCATION (City, town, or county) (State) Clearfield, Penna.	
24. REC'D BY REGISTRAR FEB 17 1956		REGISTRAR'S SIGNATURE Paul M. Beane		25. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck		ADDRESS 5305 Harford Road #14	

RECEIVED

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1476 CERTIFICATE OF DEATH

01442

Reg. Dist. No. 30

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Balto.	MARYLAND	STATE Md.	COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4 Payson Ave.		STREET ADDRESS (If rural give location) 4 Payson Ave.	
3. NAME OF DECEASED (Type or Print) (First) Charles (Middle) F. (Last) Hefner		4. DATE OF DEATH (Month) (Day) (Year) Feb. 21 1956	
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH July 24, 1887
9. AGE last birthday 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician Ret.		10b. KIND OF BUSINESS OR INDUSTRY Contractor	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Hefner		14. MOTHER'S MAIDEN NAME Lena Stedder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS Mrs. C.F. Hefner 4 Payson Ave.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) Coronary thrombosis Antecedent Cause(s) DUE TO (B) Arterio-sclerotic cordis - base, disease DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (C) DUE TO STATING UNDERLYING CAUSE LAST.		INTERVAL BETWEEN ONSET OF DEATH 4 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. 21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 18, 1956, to Feb. 21, 1956, that I last saw the deceased alive on Feb. 18, 1956, and that death occurred at 2:00 P.M. from the causes and on the date stated above.			
SIGNATURE George H. Yeager		DATE SIGNED Feb. 23, 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		24. NAME OF CEMETERY OR CREMATORY Cathedral Cem	
DATE THEREOF 2-24-56		LOCATION (City, town, or county) Balto. (State) Md.	
24. REC'D BY REGISTRAR REGISTRAR'S SIGNATURE T. E. Barry		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Farley Funeral Home, Catonsville, Md.	

CERTIFICATE OF DEATH

Form 100-100

1. DEATH IN HOUSE OR OTHER BUILDING

2. DEATH IN PUBLIC PLACE

3. DEATH IN PUBLIC PLACE

4. DEATH IN PUBLIC PLACE

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48. DEATH IN PUBLIC PLACE

49. DEATH IN PUBLIC PLACE

50. DEATH IN PUBLIC PLACE

BUREAU V. A.

FEB 24 1936

RECEIVED

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

DEPARTMENT OF HEALTH

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1801443
 Items 8,9,14 Film 193 2-26-56 et
1477 **CERTIFICATE OF DEATH** Reg. Dist. No. **38**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 55 Towson		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 55 Towson			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 60 610 Marwood Road				STREET ADDRESS (If rural give location) 610 Marwood Road			
3. NAME OF DECEASED: (First) (Middle) (Last) ELIZABETH SWIRES HENRY				4. DATE (Month) (Day) (Year) OF DEATH: February 17, 19 56			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: April 19, 1910	9. AGE last birthday 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY: Own Home		11. BIRTHPLACE (State or foreign country): Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Joseph Swires				14. MOTHER'S MAIDEN NAME: Bertha Ellen Craft			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Maynard Henry, 610 Marwood Rd., Towson, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) CEREBRAL HEMORRHAGE						1 hr	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (B) HYPERTENSION							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from FEB 17, 1956 , to — , 19 — , that I last saw the deceased alive on FEB 17, 1956 , and that death occurred at 10:50 P.M. , from the causes and on the date stated above.							
SIGNATURE Harold L. Zupnik		ADDRESS M. D. 427 Hopkins Rd		DATE SIGNED 2/19/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 21, 1956		NAME OF CEMETERY OR CREMATORY Phillipsburg Cemetery		LOCATION (City, town, or county) (State) Phillipsburg, Penna.	
DATE REC'D BY LOCAL REGISTRAR Feb. 20, 1956		REGISTRAR'S SIGNATURE Mabel C. Gray		24. FUNERAL DIRECTOR John Burns Sons		ADDRESS Towson, Maryland	

BUREAU V. S.

FEB 21 1936

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01444

1478

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Home, 8001 Duvall Ave.</u>		STREET ADDRESS <u>8001 Duvall Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>BERTHA</u> (First) <u>FRIEDA</u> (Middle) <u>HERBERT</u> (Last)		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>25</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Oct 10-1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>75</u> yrs. If under 1 year Months Days Hours Mins.
11. BIRTHPLACE (State or foreign country) <u>Switzerland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Spath</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Clarence E. 8001 Duvall Ave.</u>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>170x</u> Immediate cause (a) <u>Carcinomatosis</u> Antecedent cause(s) (b) <u>Carcinoma of Breast</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u> <u>2 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <u>10-6-54</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of breast</u>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 9-17-52, 19....., to 2-25-56, 19....., that I last saw the deceased alive on 2-25-56, 19....., and that death occurred at 2:10 p. m., from the causes and on the date stated above.

SIGNATURE James R. Mumm, M.D. (Degree or title) ADDRESS 8019 Philadelphia Rd. Balt. 6, Md. DATE SIGNED 2-25-56

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF <u>2/29/56</u>	NAME OF CEMETERY OR CREMATORY <u>Lion Luth. Cem</u>	LOCATION (City, town, or county) (State) <u>Balto Md</u>
DATE REC'D BY LOCAL REG. <u>Feb. 26</u>	REGISTRAR'S SIGNATURE <u>James R. Mumm</u>	24. FUNERAL DIRECTOR <u>Lassahn Funeral Home</u>	ADDRESS <u>7401 Belair Rd.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Sania: Mason

8019 Ph. 1a Rd

BUREAU V. S.

FEB 29 1956

RECEIVED

1386 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK</u>		c. LENGTH OF STAY IN 1b <u>LIFE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u> <u>53</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>00</u>				d. STREET ADDRESS <u>1921 MAXWELL AVE</u>			
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>J</u> Middle <u>HERMAN</u> Last				4. DATE OF DEATH Month <u>FEB</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT 12 1895</u>		9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MILL WRIGHT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL PLANT</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>AUGUST L HERMAN</u>				14. MOTHER'S MAIDEN NAME <u>MINNIE OEHM</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>HENRY L. HERMAN</u> Address <u>25 N STEEPLER ST</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Hypertensive Cardio-Vascular</u> (a), stating the underlying cause last. DUE TO <u>Disease</u> (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <u>Yes</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>M B Davis</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>M. B. DAVIS M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MARCH 1-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAKLAND</u>		22d. LOCATION (City, town, or county) (State) <u>BALTIMORE COUNTY MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wallick Funeral Home DUNDALK</u>				24a. REC'D BY REGISTRAR <u>Mar. 1, 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Mr. M. Kelly</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF MARYLAND
DEPARTMENT OF HEALTH—BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL HISTORY		POST-MORTEM EXAMINATION	
FAMILY HISTORY		PREVIOUS ILLNESS		TREATMENT		FINDINGS		OPINION		SIGNATURE	
DATE OF BIRTH		DATE OF DEATH		DATE OF EXAMINATION		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	

BUREAU V. S.

MAR 5 1956

RECEIVED

1479

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PASADENA, MD.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove Hosp.		STREET ADDRESS (If rural give location) MAGOTNY BEACH	
3. NAME OF DECEASED: (First) RAYMOND (Middle) G. RADY (Last) HICKS		4. DATE (Month) (Day) (Year) OF DEATH: FEB 12 1956	
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED July	8. DATE OF BIRTH: 1980
9. AGE last birthday 75 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fisherman		10B. KIND OF BUSINESS OR INDUSTRY: Self employed	11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME: Benjamin Hicks	
14. MOTHER'S MAIDEN NAME: Alice Grady		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —	
16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Mary Samm, Cecil Rd., Millersville, Md.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE 443X			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) Hypertensive cardiovascular disease			
DUE TO			
(B) Generalized arteriosclerosis			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2/10 , 19 56 , to 2/12 , 19 56 , that I last saw the deceased alive on 2/12 , 19 56 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.			
SIGNATURE Ernest E. Shapiro, MD.		ADDRESS Spring Grove Hosp. DATE SIGNED 2/12/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 6, 1956	
NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.		LOCATION (City, town, or county) (State) Brooklyn, T.F.D., Md.	
DATE REC'D BY LOCAL REGISTRAR Feb 15, 1956		REGISTRAR'S SIGNATURE John E. Barry	
24. FUNERAL DIRECTOR Singleton Funeral Home		ADDRESS 1144 Baltimore	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 17 1956

BUREAU V. A.

1480 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paradise Nursing Home</u>				STREET ADDRESS (If rural give location) <u>16 Dunmore Rd.</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Robert</u> (Middle) <u>C.</u> (Last) <u>Hilprecht</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 5</u> 19 <u>56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 31, 1874</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer Ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Hilprecht</u>				14. MOTHER'S MAIDEN NAME <u>---</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Robert Hilprecht 16 Dunmore</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) <u>Myocardial failure</u>				<u>5 days</u>			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Arteriosclerotic CVD</u>				<u>6 yrs</u>			
(C) <u>Benign prostatic hypertrophy</u>				<u>3 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-27</u> , 19 <u>50</u> , to <u>2-5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-4</u> , 19 <u>56</u> , and that death occurred at <u>6:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Stephen Lee Magness</u>				DATE SIGNED <u>2-7-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>2-8-56</u>		NAME OF CEMETERY OR CREMATORY <u>M.D. 908 Frederick Rd. Catonsville</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>Feb 11 1956</u>		REGISTRAR'S SIGNATURE <u>T. E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Farley Funeral Home - Catonsville, Md.</u>			

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 104

CERTIFICATE OF DEATH

Form 10-56

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. RACE

5. MARYLAND

6. COUNTY

7. DATE OF BIRTH

8. AGE

9. SEX

10. PLACE OF BIRTH

11. DATE OF DEATH

12. TIME OF DEATH

13. PLACE OF DEATH

14. CAUSE OF DEATH

15. PLACE OF DEATH

16. TIME OF DEATH

17. PLACE OF DEATH

18. CAUSE OF DEATH

19. PLACE OF DEATH

20. TIME OF DEATH

21. PLACE OF DEATH

22. CAUSE OF DEATH

23. PLACE OF DEATH

24. TIME OF DEATH

25. PLACE OF DEATH

26. CAUSE OF DEATH

27. PLACE OF DEATH

28. TIME OF DEATH

29. PLACE OF DEATH

30. CAUSE OF DEATH

31. PLACE OF DEATH

32. TIME OF DEATH

33. PLACE OF DEATH

34. CAUSE OF DEATH

35. PLACE OF DEATH

36. TIME OF DEATH

37. PLACE OF DEATH

38. CAUSE OF DEATH

39. PLACE OF DEATH

40. TIME OF DEATH

41. PLACE OF DEATH

42. CAUSE OF DEATH

43. PLACE OF DEATH

44. TIME OF DEATH

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50. CAUSE OF DEATH

51. PLACE OF DEATH

52. TIME OF DEATH

53. PLACE OF DEATH

54. CAUSE OF DEATH

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56. TIME OF DEATH

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138. CAUSE OF DEATH

139. PLACE OF DEATH

140. TIME OF DEATH

141. PLACE OF DEATH

142. CAUSE OF DEATH

143. PLACE OF DEATH

144. TIME OF DEATH

145. PLACE OF DEATH

146. CAUSE OF DEATH

147. PLACE OF DEATH

148. TIME OF DEATH

149. PLACE OF DEATH

150. CAUSE OF DEATH

151. PLACE OF DEATH

152. TIME OF DEATH

153. PLACE OF DEATH

154. CAUSE OF DEATH

155. PLACE OF DEATH

156. TIME OF DEATH

157. PLACE OF DEATH

158. CAUSE OF DEATH

159. PLACE OF DEATH

160. TIME OF DEATH

161. PLACE OF DEATH

162. CAUSE OF DEATH

163. PLACE OF DEATH

164. TIME OF DEATH

165. PLACE OF DEATH

166. CAUSE OF DEATH

167. PLACE OF DEATH

168. TIME OF DEATH

169. PLACE OF DEATH

170. CAUSE OF DEATH

BUREAU A. S.

FEB 14 1956

RECEIVED

RECEIVED

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1481 CERTIFICATE OF DEATH

Reg. Dist. No. 01448

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Balto</i>		MARYLAND		STATE <i>Pa.</i> COUNTY <i>75X-3</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Swan Oak</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Columbia</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Amesbury Home</i>				STREET ADDRESS (If rural give location) <i>681 Campfield Rd</i>			
3. NAME OF DECEASED: (Type or Print) <i>Susanna H. Hill</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>Feb 17 1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <i>Married</i>	8. DATE OF BIRTH: <i>3/7/1893</i>	9. AGE last birthday: <i>62</i> yrs		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>None</i>		11. BIRTH PLACE (State or foreign country): <i>Columbia Pa</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Benjamin F. Hubley</i>				14. MOTHER'S MAIDEN NAME: <i>Anna Albright</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <i>—</i>		17. INFORMANT & ADDRESS: <i>Records 681 Campfield Rd</i>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <i>420.0</i>				(A) <i>Arterio-Sclerotic Heart Disease</i>		INTERVAL BETWEEN ONSET AND DEATH: <i>2 yrs.</i>	
ANTECEDENT CAUSE (S):				(B) <i>—</i>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C) <i>—</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>0 None</i>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Jan - 10</i> , 1956, to <i>Feb. 17</i> , 1956, that I last saw the deceased alive on <i>Feb 16</i> , 1956, and that death occurred at <i>6 P.</i> M. from the causes and on the date stated above.							
SIGNATURE <i>Paul L. Chambers</i>		M. D.		ADDRESS <i>4108 Liberty Hts Baltimore Md - 3-17-56</i>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2/20/56</i>		NAME OF CEMETERY OR CREMATORY <i>Mt Bellet</i>		LOCATION (C. S. town, or county) (State) <i>Columbia Pa</i>	
DATE REC'D BY LOCAL REGISTRAR <i>February 18 1956</i>		REGISTRAR'S SIGNATURE <i>R.W.</i>		24. FUNERAL DIRECTOR <i>Paul L. Chambers</i>		ADDRESS <i>60671 Harbor Rd</i>	

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BOMID
OMERIE
AVILEY

1393 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>51 TOWN Baltimore (Rural)</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR TOWN Baltimore (Rural) Arbutus</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 4412 Alan Drive</u>				STREET ADDRESS (If rural give location) <u>51 4412 Alan Drive</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>William R. Hodges</u>				<u>2/27/ 19 56</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>2/16/62</u>	
				9. AGE last birthday <u>94</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U. S. Customs Store</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Richard Hodges</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>--</u>		17. INFORMANT & ADDRESS: <u>James R. Hodges 4412 Alan Drive</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Heart Disease</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>Cardiac Hypertrophy</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Cardiac Dilatation</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Feb. 3, 1956</u> to <u>Feb. 27, 1956</u> , that I last saw the deceased alive on <u>Feb. 27, 1956</u> , and that death occurred at <u>9:05 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Vincent M. Messina</u>				ADDRESS <u>M. D. 1403 S. Charles St</u>		DATE SIGNED <u>2-28-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/2/56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-1-56</u>		REGISTRAR'S SIGNATURE <u>John F. Denny</u>		24. FUNERAL DIRECTOR <u>John F. Denny, Inc.</u>		ADDRESS <u>715 Light St.</u>	

1000

14035 Class

1
INSTRUCTIONS
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1482

CERTIFICATE OF DEATH

01450

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Towson				TOWN Towson		55	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 952 Dulaney Valley Rd.				STREET ADDRESS (If rural give location) 952 Dulaney Valley Road #4			
3. NAME OF DECEASED (Type or Print) Mr. William L. Hooper				4. DATE OF DEATH (Month) February (Day) 9th (Year) 19 56			
5. SEX male		6. COLOR OR RACE white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married		8. DATE OF BIRTH Sept. 16, 1878	
9. AGE last birthday 77 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Auditor		10b. KIND OF BUSINESS OR INDUSTRY Arundel Corp		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Luther E. Hooper		14. MOTHER'S MAIDEN NAME Marie Wheeler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mrs. Anna E. Hooper, 952 Dulaney Valley Rd			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) Coronary Thrombosis				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec 19 54, to Dec 19 54, that I last saw the deceased alive on Dec 19 54, and that death occurred at 2:40 P.M. from the causes and on the date stated above.							
SIGNATURE Donist McGrath		M.D. 8358 Loch Raven Blvd.		ADDRESS (Street, city, town, state) Baltimore, Maryland		DATE SIGNED 2/9/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2/11/1956		NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. REC'D BY REGISTRAR FEB 10 1956		REGISTRAR'S SIGNATURE Nahel Krupp		25. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road #11		ADDRESS	

CERTIFICATE OF DEATH

Reg. Class No.

LEGAL MEDICAL RECORDS IN PROGRESS

NAME: [illegible]

MARRIAGE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

ETHNICITY

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS INJURY

PREVIOUS DISEASE

PREVIOUS TRAUMA

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DISEASE

PREVIOUS INJURY

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PREVIOUS TRAUMA

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DISEASE

PREVIOUS INJURY

PREVIOUS DISEASE

PREVIOUS TRAUMA

NOTIFICATION

NOTIFICATION OF DEATH TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MARYLAND. THE DEATH OF [illegible] WAS REPORTED BY [illegible] ON [illegible] AT [illegible]. THE DEATH WAS CAUSED BY [illegible]. THE DEATH WAS REPORTED BY [illegible] ON [illegible] AT [illegible]. THE DEATH WAS CAUSED BY [illegible].

BUREAU V. 8

FEB 14 1956

RECEIVED

1483

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Towson 4</u>	LENGTH OF STAY (in this place) <u>4</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson 4 (Baynesville)</u>	<u>55</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1801 Darrick Drive</u>	<u>1801 Darrick Drive</u>	STREET ADDRESS (If rural give location) <u>1801 Darrick Drive</u>	<u>1</u>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>MARY SAPP HRIB</u>		OF DEATH: <u>Feb. 6, 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH: <u>Nov. 18, 1890</u>
9. AGE last birthday <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Charles Sapp</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Edu. McHalick, Towson, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
157X IMMEDIATE CAUSE (A) <u>Carcinoma of pancreas</u>		<u>6 weeks</u>
ANTECEDENT CAUSE (S) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/15, 1955, to 2/6, 1956; that I last saw the deceased alive on 2/6, 1956, and that death occurred at 6:1 M, from the causes and on the date stated above.

SIGNATURE <u>John Burme' Som</u>	ADDRESS <u>5503 York Road Bldg</u>	DATE SIGNED <u>2/8/56</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>Feb. 9, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>
		LOCATION (City, town, or county) (State) <u>Clarksburg, W. Va.</u>
DATE REC'D BY LOCAL REGISTRAR <u>2/9/56</u>	REGISTRAR'S SIGNATURE <u>H. G. Bacon</u>	24. FUNERAL DIRECTOR <u>John Burme' Som, Towson, Md.</u>

RECEIVED

FEB 14 1956

BUREAU V. S.

1484 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH: Spring Grove State Hospital

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

52 Catonsville 28

LENGTH OF STAY (in this place)

3 years 3 mo

HOSPITAL OR INSTITUTION OR STREET ADDRESS
14 Spring Grove State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town) OR

TOWN Baltimore 17

STREET ADDRESS (If rural give location)

133 W. Lanvale Street

3. NAME OF DECEASED: (First) (Middle) (Last)

Olive

Davison

Hubner

4. DATE (Month) (Day) (Year)

OF DEATH: 2

20

19 56

5. SEX: F

6. COLOR OR RACE: W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow

8. DATE OF BIRTH: 12/13/1867

9. AGE last birthday: 88 yrs.

IF UNDER 1 YEAR Months Days

IF UNDER 24 MRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME:

George Davison

14. MOTHER'S MAIDEN NAME:

Sophie Bond

15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT & ADDRESS:

Mrs. George Thomas
200 Ridgewood Rd., Baltimore, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4500

IMMEDIATE CAUSE

(A) Pneumonia
DUE TO

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) Chronic brain syndrome associated with
DUE TO senile brain disease
(C) Arteriosclerosis, generalized

INTERVAL BETWEEN ONSET AND DEATH

3 hours

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☐ NO ☒21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21E. INJURY OCCURRED While ☐ Not while ☐ at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7- , 1953, to 2-20- , 1956, that I last saw the deceased alive on 2-20- , 1956, and that death occurred at 6:40 PM, from the causes and on the date stated above.

SIGNATURE

Sheila Wachter

M. D.

Spring Grove State Hospital

DATE SIGNED

2-20-56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Cremation

DATE THEREOF

2/23/56

NAME OF CEMETERY OR CREMATORY

Green Mount Crem.

Balto., Md.

DATE RECD BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

STATE OF NEW YORK
IN SENATE
January 12, 1911.
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1909.
ALBANY:
J. B. LEECH, STATE PRINTER.
1911.

01453

MARYLAND

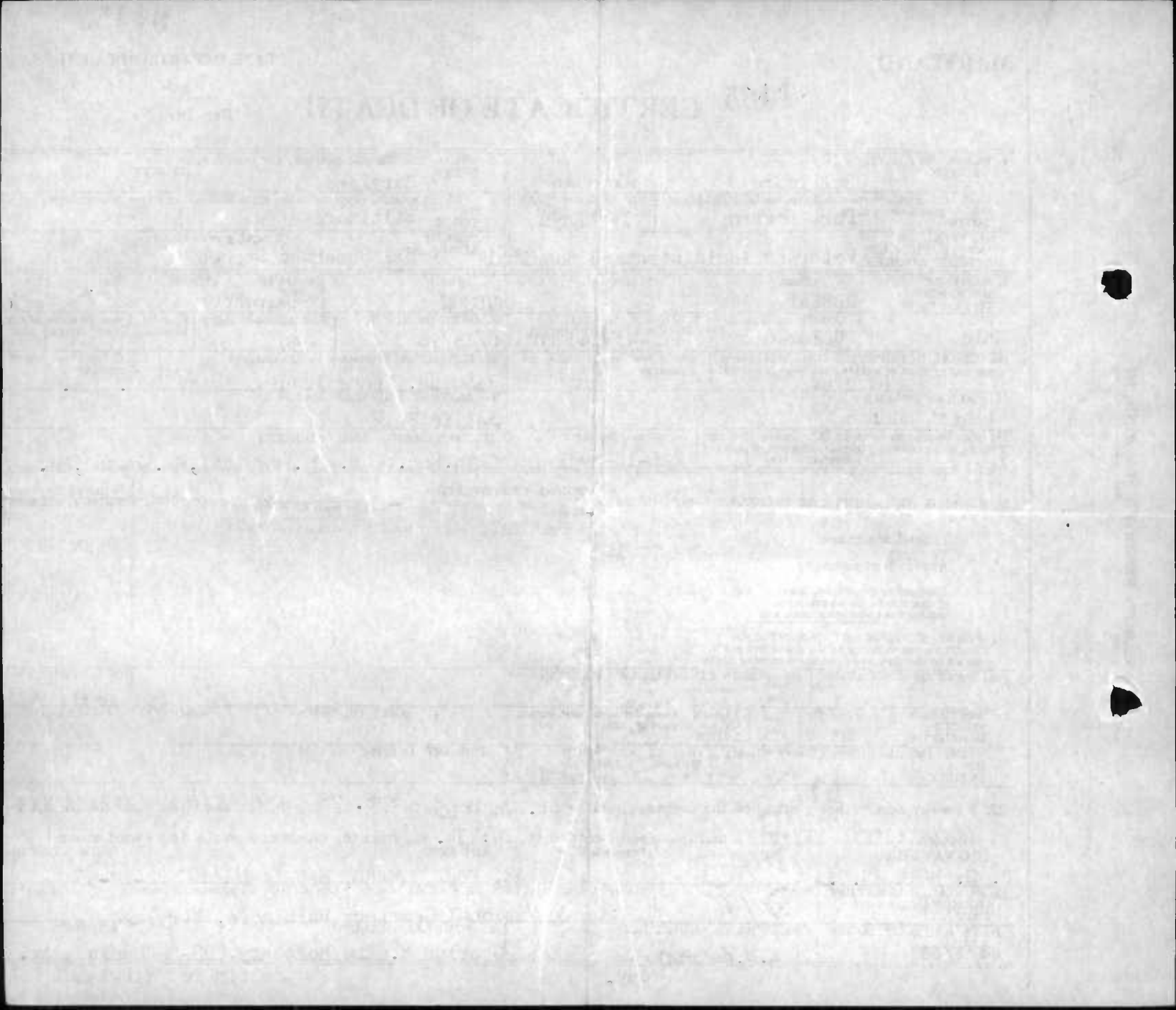
STATE DEPARTMENT OF HEALTH

1485 CERTIFICATE OF DEATH

Reg. Dist. No. KV

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Port Howard</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural, give location) <u>811 Somerset Street</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>ROBERT</u> <u>HUDSON</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>February 28</u> <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>6/15/96</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>59</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Reading, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Albert Hudson</u>		14. MOTHER'S MAIDEN NAME <u>Sallie Brim</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give year or dates of service) <u>WW I</u>		16. SOCIAL SECURITY No. <u>228-18-7987</u>	
17. INFORMANT AND ADDRESS <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>177x</u> Immediate cause (a) <u>CARCINOMA OF PROSTATE WITH GENERALIZED BONY METASTASIS</u> Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c)			UNKNOWN
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		HOW DID INJURY OCCUR? INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
22. I hereby certify that <u>VA</u> attended the deceased from <u>Sept. 24, 1955</u> , to <u>Feb. 28, 1956</u> , that I last saw the deceased <u>alive on</u> <u>XXXXXX</u> and that death occurred at <u>10:43 a.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>D. D. MARK, M.D.</u>		ADDRESS <u>VAH, FORT HOWARD, MARYLAND</u>	
DATE SIGNED <u>2-29-56</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>	
DATE <u>3/2/56</u>		LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>3/1/56</u>		24. FUNERAL DIRECTOR <u>Charles R. Law Mortuary, 802-04 Madison Av.</u>	
SIGNATURE <u>A.W. Hedrich</u>		ADDRESS <u>Baltimore, Maryland</u>	

MARGIN RESERVED FOR BINDING



1486

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
<u>Fort Howard</u>	<u>15 Days</u>	<u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<u>Veterans Administration Hospital</u>		<u>2 Chesapeake Avenue</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>JAY (NMI) HUGUNIN</u>		DEATH: <u>February 24 1956</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>10/3/89</u>
9. AGE last birthday		10. BIRTHPLACE (State or foreign country):	
<u>66 yrs.</u>		<u>Clintonville, Wis.</u>	
11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
<u>U.S.A.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Casimir Hugunin</u>		<u>Jennie Moss</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL SERVICE (Yes, no, or unknown) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
<u>Yes</u> <u>WW-I</u>		<u>218 05 7621</u>	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
<u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	

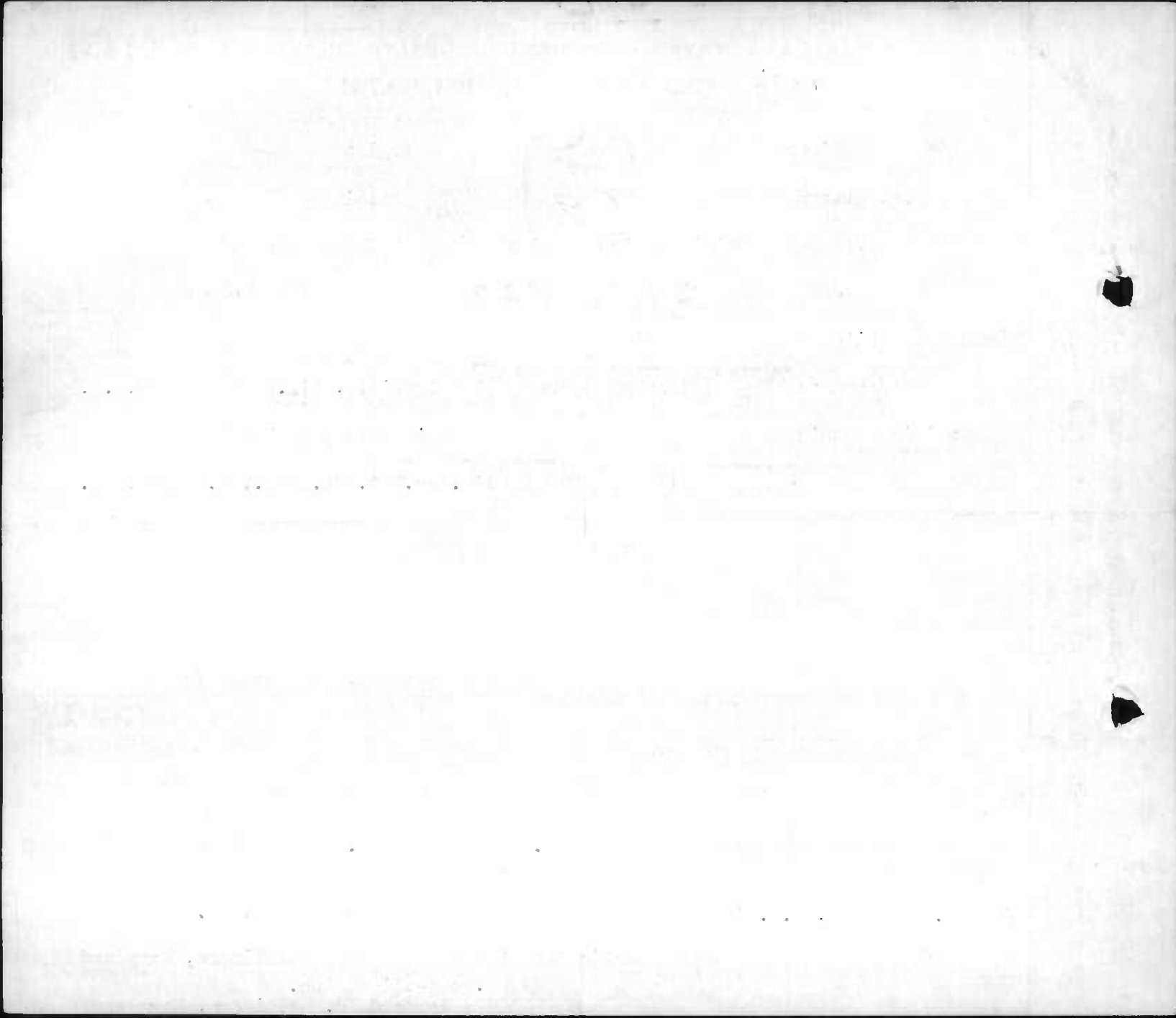
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>MYOCARDIAL INFARCTION?</u>		<u>SUDDEN</u>
ANTECEDENT CAUSE (S) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(B) DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CEREBRAL THROMBOSIS RIGHT MIDDLE CEREBRAL ARTERY WITH LEFT HEMIPLEGIA: PERNICIOUS ANEMIA</u>		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>Feb. 9</u> , 19 <u>56</u> to <u>Feb. 24</u> , 19 <u>56</u> and that death occurred at <u>2:30 P.M.</u> , from the causes and on the date stated above.		
SIGNATURE	ADDRESS	DATE SIGNED
<u>John A. Surmonte</u>	<u>VAH, Fort Howard, Md.</u>	

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>2-28-56</u>	<u>Baltimore National</u>	<u>Baltimore, Maryland</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<u>4/27/56</u>	<u>A. W. Hedrich</u>	<u>Wm. Cook-Blight Inc.</u> <u>6009 Harford Rd. Baltimore, Maryland</u>	



01455

CERTIFICATE OF DEATH

Reg. Dist. No. 50

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND	CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville</u>	STATE <u>Md</u> COUNTY <u>Prince George</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Washington 27, DC</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove St. Hospital</u>	LENGTH OF STAY (in this place) <u>38 hours</u>	STREET ADDRESS (If rural give location) <u>503 - 65 Ave NE</u>	
3. NAME OF DECEASED: (First) <u>Benjamin</u> (Middle) <u>Newton</u> (Last) <u>Hutchinson</u>		4. DATE (Month) <u>2</u> (Day) <u>19</u> (Year) <u>1956</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Oct. 23, 1887</u>
9. AGE last birthday <u>68</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Cabinet-maker</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Missouri</u>	
11. BIRTHPLACE (State or foreign country): <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Lemuel Hutchinson</u>		14. MOTHER'S MAIDEN NAME: <u>unk.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>1907-1910</u>		16. SOCIAL SECURITY NO. <u>unk.</u>	
17. INFORMANT & ADDRESS: <u>This Hosp. records</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>450.0</u> <u>Uræmia unqualified</u>		<u>unk.</u>	
ANTECEDENT CAUSE (B) <u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</u> <u>General Arteriosclerosis</u>		<u>unk.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2/18</u> , 19 <u>56</u> , to <u>2/19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/19</u> , 19 <u>56</u> , and that death occurred at <u>9:50 P</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Bruno Radauskas</u>		ADDRESS <u>M. D. Spring Grove St. Hosp.</u> DATE SIGNED <u>2/19/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>2-20-1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l.</u>		LOCATION (City, town, or county) (State) <u>WASH DC Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/23/56</u>		REGISTRAR'S SIGNATURE <u>V. E. Harris</u>	
24. FUNERAL DIRECTOR <u>Wm. H. Harker</u>		ADDRESS <u>3231 - 44 Ave NW</u>	

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 24 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

45-AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01456

1488

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>52 Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Balto</u>		3 Vol-4 ✓	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Baton Ridge Nyming</u>				STREET ADDRESS (If rural give location) <u>5412 Pembroke Ave (16)</u>		Zone	
3. NAME OF DECEASED (Type or Print) <u>Nannie S. Jenkins</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 10, 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W.</u>	8. DATE OF BIRTH <u>Nov. 22, 1878</u>	9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Fredrick H. Jenkins Phoenix Md</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>332X</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>			
ANTECEDENT CAUSE(S) DUE TO <u>Cardiac failure - 1 1/2 no stroke</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Cerebro vascular thrombosis</u>				<u>4 days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 1</u> , 19 <u>22</u> , to <u>Feb 10, 1956</u> , that I last saw the deceased alive on <u>Feb 9</u> , 19 <u>56</u> , end that death occurred at <u>10</u> <u>am</u> , from the causes and on the date stated above.							
SIGNATURE <u>W. E. Kuntz</u>				DATE SIGNED <u>2/13/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/14/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Anne's Presbyterian</u>		LOCATION (City, town, or county) (State) <u>Balto Md.</u>	
24. REC'D BY REGISTRAR <u>EB 2-1956</u>		REGISTRAR'S SIGNATURE <u>T. E. Hays</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Foring Byers</u>			
DATE				ADDRESS <u>5005 E. 7th St Balto 15, Md</u>			

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: **Spring Grove State Hospital**

2. USUAL RESIDENCE (HOME) OF DECEASED:

COUNTY **Baltimore**

MARYLAND

STATE **Maryland** COUNTY **Harford**

CITY (If outside corporate limits, write RURAL OR and give nearest town)

LENGTH OF STAY (in this place)

CITY (If outside corporate limits, write RURAL and give nearest town) OR

TOWN **Catonsville 28**

2 mos.

TOWN **Havre de Grace**

12-X-2

HOSPITAL OR INSTITUTION OR STREET ADDRESS **Spring Grove State Hospital**

STREET ADDRESS (If rural give location)

Route #1

3. NAME OF DECEASED: (First) (Middle) (Last)
Bruce ROBERT BRUCE Johnson

4. DATE (Month) (Day) (Year)
OF DEATH: **2 20 1956**

5. SEX: **M**

6. COLOR OR RACE: **W**

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): **single**

8. DATE OF BIRTH: **2-10-82**

9. AGE last birthday: **74** yrs.

IF UNDER 1 YEAR Months Days

IF UNDER 24 HRS. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): **ex-farmer**

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): **Virginia**

12. CITIZEN OF WHAT COUNTRY? **U.S.**

13. FATHER'S NAME: **Byron Johnson, Byram**

14. MOTHER'S MAIDEN NAME: **Rosie/ Rosa Boyer**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) **unk.**

16. SOCIAL SECURITY NO. **Unknown/ 212 22 9122A**

17. INFORMANT & ADDRESS: **Miss Dona Johnson, Route #1 Havre de Grace, Md.**

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

332X

IMMEDIATE CAUSE

(A) **Pneumonia, terminal**
DUE TO

9 days

ANTECEDENT CAUSE (S)

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) **Arteriosclerosis, generalized**
DUE TO

(C) **Cerebral thrombosis with left hemiparesis**

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: **0**

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) (County) (State)
INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐
at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **12-21-1955**, to **2-20-1956**, that I last saw the deceased alive on **2-20-1956**, and that death occurred at **9:50P M.** from the causes and on the date stated above.

SIGNATURE

Stella Wade

ADDRESS **Spring Grove State Hospital** DATE SIGNED **2-21-56**

23. BURIAL, CREMATION, DATE THEREOF REMOVAL (SPECIFY)

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county) (State)

Burial

Feb. 23, 1956 Rock Run Cms Harford Co Md

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

2/21/56 W.E. Garry A.S. Bailey, Baltimore Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 23 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

1490 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

Item 9, Film G193 3-6-56 et

1. PLACE OF DEATH: COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CHATHAM LEE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CHATHAM LEE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VALLEY ROAD</u>		STREET ADDRESS (If rural, give location) <u>VALLEY ROAD</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>HIRAN</u> <u>SORRELL</u> <u>JONES</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2</u> - <u>10</u> - <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>DIVORCED</u>	8. DATE OF BIRTH <u>6-16-1896</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>GARDENING</u>	9. AGE last birthday <u>59</u> yrs.
10. FATHER'S NAME <u>THOMAS H. JONE</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
16. SOCIAL SECURITY NO. <u>no</u>		14. MOTHER'S MAIDEN NAME <u>ELLA BUTLER</u>	
17. INFORMANT AND ADDRESS <u>Mollie Duggs - Valley Road</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>353.3</u> <u>accidental Drowning</u>		
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>9298</u> <u>Epilepsy</u>		
(c) OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none.</u>		
19a. DATE OF OPERATION <u>none.</u>	19b. MAJOR FINDINGS OF OPERATION <u>none.</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. EXTERNAL CAUSE PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY <u>Spring in woods. Harrison</u>	(CITY OR TOWN) <u>Balto. Md</u>	(COUNTY) <u>Balto. Md</u>	(STATE) <u>Balto. Md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>2</u> <u>6</u> <u>56</u> <u>4</u> p.m.	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Had seizure & drowned in spring.</u>			

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE <u>D.D. Caples</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>Riverton, Md</u>		DATE SIGNED <u>2-10-56</u>	
23. BURIAL, CREMATION OR MOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2/11/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Lukes</u>		LOCATION (City, town, or county) (State) <u>Riverton, Md</u>	
DATE REC'D BY LOCAL REGISTRY <u>2/11/56</u>		REGISTRAR'S SIGNATURE <u>Mollie Duggs</u>		24. FUNERAL DIRECTOR <u>Frank H. Newell - Baltimore</u>		ADDRESS <u>Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 24 1951

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01459

1491

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>38 Dunvegan Rd.</u>				STREET ADDRESS (If rural give location) <u>38 Dunvegan Rd.</u>			
3. NAME OF DECEASED (Type or Print) <u>Addie Owens Kane</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 10, 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Jan. 25, 1881</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress Ret</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing Mfg</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>-- Owens</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>--</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Aubrey O Kane 38 Dunvegan Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
442X IMMEDIATE CAUSE (A) <u>Myocardial Decompensation</u>						INTERVAL BETWEEN ONSET AND DEATH <u>17mo</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chr. Hypertensive Cardio-Vasc - Renal Disease</u>						<u>10yr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-28</u> , 19 <u>55</u> , to <u>2-10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-9</u> , 19 <u>56</u> , and that death occurred at <u>7:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William R. Fullagar</u>				ADDRESS (Street, city, town, state) <u>M. 662097 Frederick Rd Balt. 28, Md</u>			
DATE SIGNED <u>2/11/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-13-56</u>		NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>FEB 12 1956</u>		REGISTRAR'S SIGNATURE <u>T. E. Farney</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Forley Funeral Home, Catonsville, Md.</u>		ADDRESS	

CERTIFICATE OF DEATH

File No. 10

NAME OF DECEASED

AGE

SEX

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

US BIRTH

ALIEN BIRTH

DATE OF ARRIVAL

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

EDUCATION

OCCUPATION

RELIGION

US BIRTH

ALIEN BIRTH

DATE OF ARRIVAL

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

BUREAU V. S.

FEB 14 1921

RECEIVED

SHORTLY AFTER

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1492 CERTIFICATE OF DEATH

Reg. Dist. No.

01460

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN FORT HOWARD	LENGTH OF STAY (in this place) 15 hrs; 15 min.	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BALTIMORE	3Y01-4
HOSPITAL OR INSTITUTION OR STREET ADDRESS VAH, FORT HOWARD, MARYLAND	STREET ADDRESS (If rural give location) 517 N. Loudon Avenue		
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH:	
OSCAR S. KEIM		February 22, 1956	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: May 14, 1874
9. AGE last birthday: 81 yrs.		10. BIRTHPLACE (State or foreign country): Tunkhannock, Pennsylvania	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Storekeeper's Clerk		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Franklin Keim		14. MOTHER'S MAIDEN NAME: Josephine Vosburg	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service): Yes SAW		16. SOCIAL SECURITY NO.: 207-01-7523	
17. INFORMANT & ADDRESS: Vet. Adm. Hosp. Clin. Rec., Ft. Howard, Md.		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) ARTERIOSCLEROTIC HEART DISEASE		9 MONTHS	
ANTECEDENT CAUSE (S) GENERALIZED ARTERIOSCLEROSIS		UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) CEREBRAL THROMBOSIS, RIGHT MIDDLE CEREBRAL ARTERY	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		5 YEARS	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that VA attended the deceased from Feb. 21, 1956 , to Feb. 22, 1956 , and that death occurred at 2:15 AM , from the causes and on the date stated above.			
SIGNATURE W. C. Dudley, M.P.		DATE SIGNED 2-22-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF FEB. 24, 1956	
NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR Feb 23, 1956		REGISTRAR'S SIGNATURE W. C. Dudley	
24. FUNERAL DIRECTOR Witzke Funeral Directors		ADDRESS 4101 Edmondson Ave., Baltimore, Md.	

2

THE UNITED STATES OF AMERICA
DEPARTMENT OF THE ARMY
OFFICE OF THE CHIEF OF STAFF
WASHINGTON, D. C.
1945

MEMORANDUM FOR THE CHIEF OF STAFF
SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

21. [Illegible]

22. [Illegible]

23. [Illegible]

24. [Illegible]

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96. [Illegible]

97. [Illegible]

98. [Illegible]

99. [Illegible]

100. [Illegible]

1492 Item 12, Film 92 2-20-56 et

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. NAME OF DECEASED (Type or Print)		2. DATE OF DEATH	
Clara King		Feb 11, 1956	
3. PLACE OF DEATH:		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
A. Baltimore City, Maryland		A. STATE Maryland	
B. FULL NAME OF HOSPITAL OR INSTITUTION		B. COUNTY	
The House in the Pines Md 16 Fusting Ave, Catonsville		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore	
c. Length of stay in Baltimore		D. STREET ADDRESS (If rural, give location)	
Yrs. Mos. Days		2601 Madison Ave. Temple Garden Apt	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH
Female	White	Widow	Aug 1, 1867
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday)	11. BIRTHPLACE (State or foreign country)
Housework		88	Germany
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	12. CITIZEN OF WHAT COUNTRY?	
Raphael Wolf	Rosina Sonneberg	U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
		Louis Rosenstein, 2601 Madison Ave	

18.	420.1	I	CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH
			DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		
			(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		
			(A) <u>Acute Coronary Thrombosis</u> DUE TO		<u>1 hour</u>
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.					
(B) <u>arteriosclerosis & senility</u> <u>chronic coronary disease</u> DUE TO					
(C)					

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING IT.

C	19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY?
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II			YES <input type="checkbox"/> NO <input type="checkbox"/>

M	21d. TIME (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?
	OF INJURY				WHILE AT WORK <input type="checkbox"/>	NOT WHILE AT WORK <input type="checkbox"/>	

22. I certify that (I) (this hospital) attended the deceased from Dec. 27 1952 to Feb. 11 1956, that (I) (we) last saw the deceased alive on Feb. 9 1956, and that death occurred at 12:45 m. from the causes and on the date stated above.

23A. SIGNATURE <i>Dr. Bernard J. Cohen</i> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.	23B. ADDRESS <i>The Manhattan Ast</i>	23C. DATE SIGNED <i>2-11-56</i>
--	--	------------------------------------

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 2-13-56	24c. NAME OF CEMETERY OR CREMATORY Oheb Shalom Cemetery	24d. LOCATION (City, town, or county) (State) Baltimore, Maryland
---	----------------------	--	--

DATE RECEIVED BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
FEB 12 1956	<i>[Signature]</i>	David B. Martin	1902 Eutaw Place

THIS IS A PERMANENT RECORD.
PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.
Every item of information be carefully supplied. Physicians: please write the causes of death clearly and leg-
THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

RECEIVED

FEB 16 1956

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01462

1494 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (in this place) <u>10 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 331 Oella Avenue</u>		STREET ADDRESS (If rural give location) <u>331 Oella Avenue</u>					
3. NAME OF DECEASED (Type or Print) <u>GEORGIA</u> (First) <u>KNABE</u> (Middle) (Last)				4. DATE OF DEATH (Month) <u>February</u> (Day) <u>8</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>February 9, 1880.</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Judson Boswell</u>				14. MOTHER'S MAIDEN NAME <u>Martha Ann Severen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Ernest Knabe Route 3, Box 40 Ellicott City, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
491X IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>-</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>-</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>-</u>							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/6</u>, 19<u>56</u>, to <u>2/8</u>, 19<u>56</u> that I last saw the deceased alive on <u>2/7</u>, 19<u>56</u>, and that death occurred at <u>3 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>George E. Burdett</u> M.D.				ADDRESS (Street, city, town, state) <u>Church St. Ellicott City, Md.</u>		DATE SIGNED <u>2/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 11, 1956.</u>		NAME OF CEMETERY OR CREMATORY <u>Good Shepherd Cemetery</u>		LOCATION (City, town, or county) (State) <u>Ellicott City, Maryland.</u>	
24. REC'D BY REGISTRAR DATE <u>2/9/56</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Easton Sons, Catonsville 28, Md.</u>			

01463

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

194 CERTIFICATE OF DEATH

NAME OF DECEASED WILLIAM J. LANE		DATE OF DEATH JANUARY 14, 1956	
PLACE OF DEATH HOME		CITY BALTIMORE	
COUNTY BALTIMORE		STATE MARYLAND	
AGE 68		SEX MALE	
RACE WHITE		EDUCATION HIGH SCHOOL	
OCCUPATION RETIRED		MARRIAGE MARRIED	
CAUSE OF DEATH HEART DISEASE		IMMEDIATE CAUSE CORONARY THROMBOSIS	
MANNER OF DEATH NATURAL		CERTIFICATE NO. 12345	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
DATE OF SIGNATURE		DATE OF SIGNATURE	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSES. IT IS THE POLICY OF THE DEPARTMENT TO MAINTAIN THE ACCURACY OF THIS INFORMATION AND TO PROVIDE A COMPLETE RECORD OF THE DEATH OF EACH INDIVIDUAL WHO DIES IN THE STATE OF MARYLAND.

RECEIVED
FEB 14 1956
BUREAU V. S.

1394

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 51 Relay				c. LENGTH OF STAY IN 1b 30 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Viaduct Ave.				d. STREET ADDRESS Viaduct Ave.			
3. NAME OF DECEASED (Type or print) Emory E. Knode, Sr.				4. DATE OF DEATH February 25 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 24, 1880	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor		10b. KIND OF BUSINESS OR INDUSTRY B.&O.R.R.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Knode				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Charles B. Knode 1007 Francis Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Bladder DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Carcinomatosis DUE TO (c) Myocardial Infarct				INTERVAL BETWEEN ONSET AND DEATH 6 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept 1930 , to Feb 25 1956 , that I last saw the deceased alive on Feb 25 1956 , and that death occurred at 30 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE R. B. Baumgardner M.D.				ADDRESS (Street, city or town, state) 56 59 Main St Baltimore, Md			
PHYSICIAN'S NAME (Type) Edbridge 27 Md				DATE SIGNED 2/27/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 28, 1956		22c. NAME OF CEMETERY OR CREMATORY Loudon Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ambrose Inc. 1328 Sulphur Spring Rd.				24a. REC'D BY REGISTRAR DATE 29 1956		24b. REGISTRAR'S SIGNATURE Dr. Geo. F. M. Leffer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Baltimore

Maryland

Baltimore

Relay

Relay

Vindict Ave.

Vindict Ave.

Wesley R. Knobe, Jr.

February 20

June 24, 1880

White

Male

Maryland

P.O. R.R.

Supervisor

Unknown

John Knobe

Charles E. Knobe 1007 Francis Ave.

BUREAU A. 7

FEB 29 1956

RECEIVED

Baltimore, Maryland

Bureau of Health, 1200 Spring Rd.
Baltimore, Md. 21206

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01464

1495

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Sparrows Point		LENGTH OF STAY (In this place) 47 years		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Sparrows Point			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 7409 North Point Road				STREET ADDRESS (If rural, give location) 7409 North Point Road			
3. NAME OF DECEASED (First) JOHN		(Middle) OSCAR		(Last) KOLSTROM		4. DATE OF DEATH (Month) (Day) (Year) Feb. 12 19 56	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH Dec. 25, 1890	9. AGE last birthday 65 yrs.	If under 1 year Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heater		10b. KIND OF BUSINESS OR INDUSTRY Steel Co.		11. BIRTHPLACE (State or foreign country) Finland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Kolstrom				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) No.		16. SOCIAL SECURITY No. 213-07-2883		17. INFORMANT Mrs. Hilma Kolstrom 7409 North Point Road			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
420.0 Immediate cause (a) Coronary Thrombosis			2 hrs
Antecedent cause(s) (b) Arteriosclerotic H.T. Disease			3 yrs
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **Oct**, 19**55**, to **Feb. 12**, 19**56**, that I last saw the deceased alive on **Feb. 12**, 19**56**, and that death occurred at **2:00 A.** m., from the causes and on the date stated above.

SIGNATURE James T. Means		(Degree or title)		ADDRESS 520 St. Balt. 19 2nd		DATE SIGNED 2/13/56	
23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE Feb. 15, 1956	NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		LOCATION (City, town, or county) Colgate, Md.		(State)	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE Feb. 13-56		24. FUNERAL DIRECTOR Ulrich Funeral Home		ADDRESS 2112 Dundalk Ave.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 15 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1496 CERTIFICATE OF DEATH

01465

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Catonsville</u>				TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>House in the Pines</u>				STREET ADDRESS (If rural give location) <u>210 Shady Nook Court</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Ernest Reinhold Kopelke</u>				<u>Feb. 17 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>Single</u>	<u>July 21, 1888</u>	<u>67</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Gardener</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Private Homes</u>		11. BIRTHPLACE (State or foreign country) <u>Wisc.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Fred Kopelke</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Hardt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>William Kopelke 210 Shady Nook C</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
442X IMMEDIATE CAUSE (A) <u>Myocardial Decompensation</u>						INTERVAL BETWEEN ONSET AND DEATH <u>12mo</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Arteriosclerosis - Renal Disease</u>						<u>5yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10-23</u> , 19 <u>53</u> , to <u>2-17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-17</u> , 19 <u>56</u> , and that death occurred at <u>4:30 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Wilmer K. Gallagher</u>				DATE SIGNED <u>2-20-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>2-21-56</u>		NAME OF CEMETERY OR CREMATORY <u>Balto. National Cem.</u>	
				LOCATION (City, town, or county) <u>Balto.</u>		(State) <u>MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>FEB 23 1956</u>		<u>V. E. Harvey</u>					

01-102

CERTIFICATE OF DEATH

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

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NAME OF CLERGYMAN

NAME OF CLERGYMAN

NAME OF CLERGYMAN

BUREAU V. S.

FEB 23 1956

RECEIVED

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	BALTO.	STATE	MD
CITY (If outside corporate limits, write RURAL and give nearest town)	SPARROWS POINT (19)	COUNTY	BALTO.
OR TOWN	SPARROWS POINT (19)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	SPARROWS POINT (19)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	RURAL ROUTE BOX #302	STREET ADDRESS (If rural give location)	RURAL ROUTE 10 - BOX #302
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
WILBUR GEORGE KYLE		FEB. 24 1956	
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify):	8. DATE OF BIRTH:
M.	W.	MARRIED	JULY 22, 1874
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):
HILLWRIGHT HELPER		STEEL MFR	W. VA.
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
JOHN KYLE		SARAH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service):		17. INFORMANT & ADDRESS:	
NO		JAMES W. KYLE 3446 McSHANE WAY DUNDALK 22, MD	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
213-07-6675		JAMES W. KYLE 3446 McSHANE WAY DUNDALK 22, MD	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
443X IMMEDIATE CAUSE			3 days.
(A) Cerebral Vascular Accident			
ANTECEDENT CAUSE (S)			
(B) Hypertensive Arteriosclerotic Cardiovascular Disease.			
(C) Senility			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		20. AUTOPSY?	
0		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 6, 1956, to Feb. 24, 1956, that I last saw the deceased alive on Feb. 23, 1956, and that death occurred at 2:18 P.M. from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
David Quinn, M.D.		2/24/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
BURIAL		OAK LAWN	
24. FUNERAL DIRECTOR		ADDRESS	
FEL		Dawson L. Lefkowitz, Walter R. Ruddy, Randolph, Md.	

BUREAU V. S.

FEB 28 1956

RECEIVED

1498 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>JESSUPS</u>			
X <u>50</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>		<u>87 Days</u>		STREET ADDRESS (If rural give location) <u>Box 54</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>JOSEPH (Juo zapas) (NMI) LATVANAS</u>				<u>February 12 1956</u>			
5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>8-18-93</u>	
9. AGE last birthday: <u>62</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Cement Finisher</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Joseph Latvanas</u>		14. MOTHER'S MAIDEN NAME: <u>Eva (MN: Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW-1</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.1</u> <u>INFARCTION OF MYOCARDIUM DUE TO ARTERIO</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 MONTHS</u>			
ANTECEDENT CAUSE (B) <u>DUE TO</u> <u>SCLEROTIC CORONARY THROMBOSIS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>002.8</u> (C) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>				<u>4 YEARS</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>PULMONARY TUBERCULOSIS</u>							
19A. DATE OF OPERATION: <u>0</u> 19B. MAJOR FINDINGS OF OPERATION							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		21F. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>Nov. 17, 1955</u> , to <u>Feb. 12, 1956</u> , that I last saw the deceased <u>alive on 19-10-55</u> , and that death occurred at <u>9:00 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>C. B. COPE, M.D.</u>		M. D. <u>VAH, Fort Howard, Maryland</u>		DATE SIGNED <u>2-12-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-15-56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-14-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>William Cook-Blight Inc. Funeral Home</u>		ADDRESS <u>6009 Harford Ave., Baltimore 14, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

59-112-

[illegible]

2005-06-01

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25

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

1082

1499 CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chase, Md.</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chase, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eastern Ave</u>				STREET ADDRESS (If rural give location) <u>Eastern Ave</u>			
3. NAME OF DECEASED: (First) <u>Hate</u> (Middle) <u>Lay</u> (Last) <u>Lay</u>				4. DATE OF DEATH: (Month) <u>Feb</u> (Day) <u>6</u> (Year) <u>1956</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Oct. 25, 1866</u>	9. AGE last birthday: <u>89</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>		11. BIRTHPLACE (State or foreign country): <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Reinhardt</u>				14. MOTHER'S MAIDEN NAME: <u>Hate Haas</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>—</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Catherine Chenoweth 329 1/2 Chester Ave. Balto. 18</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>490X</u> Immediate cause (a) <u>Tubar Pneumonia</u> Antecedent causes (s) (b) <u>Arteriosclerotic Cardiovascular disease</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)		<u>1 day</u> <u>2 yrs</u>

11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
SUICIDE	INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 2, 1956, to Feb 6, 1956, that I last saw the deceased alive on Feb 6, 1956, and that death occurred at 9 PM, from the causes and on the date stated above.

SIGNATURE M. B. Gardner (Degree or title) M.D. ADDRESS Balto. Md. DATE SIGNED 2/8/56

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3/10/56</u>	<u>St. Michaels Luth.</u>	<u>Balto.</u>	<u>Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>Feb 9, 1956</u>	<u>G. W. Hedrich</u>	<u>Larrah Funeral Home</u>	<u>7401 Belair Rd.</u>	

MARGIN RESERVED FOR BINDING

STATE OF NEW YORK
IN SENATE
JANUARY 1, 1901.
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1899.
ALBANY:
J. B. LIPPINCOTT & CO.,
PRINTERS.
1901.

RECEIVED JAN 1 1901

1520

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Balto.	MARYLAND	STATE Md.	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Catonsville	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 16 Fusting Ave.	(House in Fines)	STREET ADDRESS (If rural give location) 1656 Northgate Rd.	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
CLARA B. LEASE		Feb. 18 19 56	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
female	white	widowed	Oct. 5, 1869
9. AGE last birthday		10. AGE last birthday	
86 yrs.		86 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
Homemaker		at home	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Md.			
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
John Gwynn Tibbals		-	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
-			
17. INFORMANT & ADDRESS:			
Mr. H. Gwynn Lease-1656 Northgate Rd.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE 443X			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) Myocardial Decompensation			10 da.
(B) Ch. Hypertensive Cardia. Vascular Disease			15 yr. (?)
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
0			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 10-4 , 19 55 , to 2-18 , 19 56 , that I last saw the deceased alive on 2-18 , 19 56 , and that death occurred at 2:15 P.M. from the causes and on the date stated above.			
SIGNATURE William K. Gallagher		ADDRESS M. D. Catonsville-282nd	
DATE SIGNED 2-20-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Burial		2/21/56	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Mt. Olivet Cem.		Balto., Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
Feb 20, 1956		G. W. Hedrich	
24. FUNERAL DIRECTOR		ADDRESS	
Wm. J. Vickers & Sons		Balto 17th	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1501

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 33

1. PLACE OF DEATH - COUNTY <u>Balto</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hawblesburg</u>		LENGTH OF STAY (In this place) <u>30 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hawblesburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>EMMA - ETTA - LEIGHT</u>		(First) (Middle) (Last)		4. DATE OF DEATH <u>Feb 14</u> 19 <u>56</u>	
5. SEX <u>H</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 13-1896</u>	9. AGE last birthday <u>59</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>md</u>	
13. FATHER'S NAME <u>John S Myers</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Williams</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>md</u>		16. SOCIAL SECURITY No. <u>no</u>		17. INFORMANT AND ADDRESS <u>Blanche Leight, Hawblesburg md</u>	
18. MEDICAL CERTIFICATION					
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Artery Disease</u>					<u>1 hr</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Varicose Veins.</u>					<u>20 yrs.</u>
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>none</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>		PLACE (Home, farm, factory, street, or office bldg., etc.) <u>none</u>		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u> m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>none</u>		HOW DID INJURY OCCUR? <u>none</u>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .					
SIGNATURE <u>D. D. Caples</u>		(Degree or title) <u>MD</u>		ADDRESS <u>Reisterstown, Md.</u> DATE SIGNED <u>2-15-56</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Feb 17/56</u>		NAME OF CEMETERY OR CREMATORY <u>Cremory</u> LOCATION (City, town, or county) (State) <u>md</u>	
DATE REC'D BY LOCAL REG. <u>2-16-56</u>		REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>		24. FUNERAL DIRECTOR <u>Edward Caples</u> ADDRESS <u>Hawblesburg md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 20 1956

BUREAU V. R.

1552 CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print) <i>Alice Louise Lennert</i>			2. DATE OF DEATH <i>2/12/56</i>		
3. PLACE OF DEATH: <i>Baltimore, Maryland - Stoneleigh</i>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md</i> B. COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>812 Register Ave</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Balto</i> <i>3401-4</i>		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>5500 Lombardy Place</i> ✓		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Aug 29 1881</i>	9. AGE (In years last birthday) <i>73</i>	If Under 1 Year Months Days <i>5 13</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>		
11. BIRTHPLACE (State or foreign country) <i>Balto, Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>John Browne</i>			14. MOTHER'S MAIDEN NAME <i>Katherine Sloane</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT <i>Mrs. Randolph Mollenhrich</i>			ADDRESS		

18. <i>157X</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <i>Carcinoma, Head of Pancreas with jaundice</i>	CAUSE OF DEATH (A) <i>Carcinoma, Head of Pancreas with jaundice</i> DUE TO	INTERVAL BETWEEN ONSET AND DEATH <i>2 mo.</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) <i>Arteriosclerotic Cardio-vascular Disease</i> DUE TO	(B) <i>Arteriosclerotic Cardio-vascular Disease</i> DUE TO	<i>24 hrs.</i>
(C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <i>Cerebral Vascular Accident</i>	19. <i>1 yr.</i>
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IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II	19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
---	---	----------------------------

22. I certify that (I) (this hospital) attended the deceased from *Dec. 1954* to *Feb. 1956*, that (I) (we) last saw the deceased alive on *Feb. 10*, 1956, and that death occurred at *10 A.* m., from the causes and on the date stated above.

23A. SIGNATURE <i>Wm H. Hammer, Jr.</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	23B. ADDRESS <i>5015 Shandon Ave.</i>	23C. DATE SIGNED <i>2/13/56</i>
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24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	24B. DATE <i>2/15/56</i>	24C. NAME OF CEMETERY OR CREMATORY <i>Woodlawn</i>	24D. LOCATION (City, town, or county) (State) <i>Woodlawn Md.</i>
--	-----------------------------	---	--

DATE RECEIVED BY LOCAL REGISTRAR <i>2-14-56</i>	REGISTRAR'S SIGNATURE <i>A. W. Hedlund</i>	25. FUNERAL DIRECTOR <i>Wm Cook, Inc.</i>	ADDRESS <i>1217 St. Paul st.</i>
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THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

19

1593 CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Prince Georges	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Owings Mills		LENGTH OF STAY (in this place) 2 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) OR Hyattsville		16-15-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rosewood State Tr. School				STREET ADDRESS (If rural give location) 8215-14th Avenue			
3. NAME OF DECEASED: (Type or Print) Phillip		(First) (Middle) (Last) Levine		4. DATE (Month) (Day) (Year) OF DEATH: 2 2 19 56			
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: 6/29/53	9. AGE last birthday: 2 yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --		10B. KIND OF BUSINESS OR INDUSTRY: --		11. BIRTHPLACE (State or foreign country): Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Leo Levine				14. MOTHER'S MAIDEN NAME: Shirley Breslow			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) --		16. SOCIAL SECURITY NO. --		17. INFORMANT & ADDRESS: Rosewood Records			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Acute Bronchitis			
IMMEDIATE CAUSE (A) Pneumonitis		DUE TO		Broncho. pneumonia			
ANTECEDENT CAUSE (B) Hydrocephaly		DUE TO		24 hrs.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				since birth			
(C) Malnutrition							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2/1 , 19 56 , to 2/2 , 19 56 , that I last saw the deceased alive on 2/2 , 19 56 , and that death occurred at 9:00 a.m. from the causes and on the date stated above.							
SIGNATURE Mary B. Butler		M. O. Owings Mills, Md.		DATE SIGNED 2/2/56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) 2-2-56		NAME OF CEMETERY OR CREMATORY Mary B. Shine		LOCATION (City, town, or county) Wash. D.C.		(State)	
OATE REC'D BY LOCAL REGISTRAR 2-2-56		REGISTRAR'S SIGNATURE Mary B. Shine		24. FUNERAL DIRECTOR Goldberg Funeral Home		ADDRESS 4217-9th St NW Wash DC	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 6 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film 93 3-1-56 et

01474

CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH: 1574		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Pikesville</u>	<u>15 years</u>	TOWN <u>Pikesville & Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Orchard Rd.</u>		STREET ADDRESS (If rural give location)	<u>Orchard Rd.</u>
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Bridget Agnes Lingg</u>		DATE OF DEATH: <u>Feb 14</u> <u>1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Oct 15, 1884</u>
9. AGE last birthday: <u>70 yrs.</u>		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>	
11. BIRTHPLACE (State or foreign country): <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Patrick Dougherty</u>		14. MOTHER'S MAIDEN NAME: <u>Margaret Donnelly</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>yes</u> <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Orchard Rd. Benjamin Lingg, Pikesville & Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cirrhosis of liver</u>			<u>3 mos.</u>
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. HOW DID INJURY OCCUR?	
21G. WHILE <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
22. I hereby certify that I attended the deceased from <u>28 Nov.</u> , 19 <u>53</u> , to <u>14 Feb.</u> , 19 <u>56</u> that I last saw the deceased alive on <u>14 Feb.</u> , 19 <u>56</u> , and that death occurred at <u>9:40</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Paul H. Rouse</u>		DATE SIGNED <u>14 Feb 56</u>	
ADDRESS <u>Pikesville & Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb 17, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Union Ridge Cemetery</u>		LOCATION (City, town, or county) <u>Pikesville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR <u>Frank H. Newell, Pikesville</u>	

EVONIE V

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01475

1575 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notch Cliff near Towson</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Notch Cliff, Md. near Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Villa Maria Glenview Rd</u>		STREET ADDRESS <u>Glenview Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Sr. M. Cantalicia Magin</u>		4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>26</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Single</u>	8. DATE OF BIRTH <u>April 7, 1869</u>
9. AGE last birthday <u>86</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>	
11. BIRTHPLACE (State or foreign country) <u>Rochester, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Marvin Magin</u>		14. MOTHER'S MAIDEN NAME <u>Mary Engbert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>St. Mary Clara NOTCH CLIFF NR TOWSON, MD.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Respiratory failure due to metastasis</u>		<u>1 wk</u>
Antecedent cause(s) (b) <u>Carcinoma of ascending colon</u>		<u>5 yrs.</u>
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 22, 1953, to Feb. 26, 1956, that I last saw the deceasedalive on Feb. 21, 1956, and that death occurred at 12:50 P. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>2-28-56</u>	<u>VILLA MARIA CEM.</u>	<u>NOTCH CLIFF NR TOWSON, MD.</u>
DATE REG'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	FUNERAL DIRECTOR	ADDRESS
<u>2-28-56</u>	<u>Charles S. Guler</u>	<u>9015 CONKLIN ST.</u>	<u>BALTO., 24, MD.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6.2.1.1



1506 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE MARYLAND				STATE MARYLAND COUNTY BA.			
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN FORT HOWARD				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ANNAPOLIS 02-X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) Rt.#4, St. MARGARETTES ✓			
3. NAME OF DECEASED: (First) (Middle) (Last) AUGUST CARL MATTES				4. DATE (Month) (Day) (Year) OF DEATH: February 10, 1956			
5. SEX: MALE		6. COLOR OR RACE: WHITE		7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): WIDOWED		8. DATE OF BIRTH: 9-10-91	
				9. AGE last birthday 64 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman				10B. KIND OF BUSINESS OR INDUSTRY: Automobile		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME: CHRISTIAN MATTES				14. MOTHER'S MAIDEN NAME: HERMOINE BREINING			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW-1				16. SOCIAL SECURITY No. 213-01-9778		17. INFORMANT & ADDRESS: Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Md.	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) APLASTIC ANEMIA		UNKNOWN
DUE TO		
ANTECEDENT CAUSE (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 10, 1956 , to Feb. 10, 1956 , and that death occurred at 11:25 PM , from the causes and on the date stated above.					
SIGNATURE C. D. Mark, M.D.		ADDRESS VAH, Fort Howard, Maryland		DATE SIGNED 2-12-56	
23. BURIAL. CREMATION. REMOVAL (SPECIFY) BURIAL		DATE THEREOF 2/14/56		NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery LOCATION (City, town, or county) Baltimore, Maryland (State)	
DATE REC'D BY LOCAL REGISTRAR 2-13-56		REGISTRAR'S SIGNATURE [Signature]		24. FUNERAL DIRECTOR Leonard J. Huck Funeral Home ADDRESS 5309 Harford Rd., Baltimore, Md.	

THANK

A-5-1-1

ALPINE TRAIL

ALPINE TRAIL

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01477

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>md.</i>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Cockeysville</i>		<i>12 years</i>		TOWN <i>Frederick</i>		<i>10-11-2</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Masonic Home</i>				STREET ADDRESS (If rural give location) <i>Francis Scott Key Hotel</i>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<i>Mary Bowers Maynard</i>				<i>Feb. 7 1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>White</i>		<i>Dec. 15, 1867</i>	<i>88</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Clerical Worker</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
					<i>Virginia</i>		<i>U.S.</i>
13. FATHER'S NAME <i>Jacob Thomas Bowers</i>				14. MOTHER'S MAIDEN NAME <i>Sallie Markwood Wolfe</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<i>Frank R. Smith Jr. Cockeysville, Md.</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
4201 IMMEDIATE CAUSE (A) <i>Cornary Occlusion</i>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb. 4</i> , 19 <i>49</i> , to <i>Feb. 6</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Feb. 6</i> , 19 <i>56</i> , and that death occurred at <i>9:35 A.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Walter T. Hues</i>				ADDRESS (Street, city, town, state) <i>Cockeysville Md.</i>		DATE SIGNED <i>2/7/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>2/9/56</i>		NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>		LOCATION (City, town, or county) (State) <i>Frederick Maryland</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <i>Frank Smith</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Wm. Cook Inc.</i>		ADDRESS <i>1217 St. Paul St.</i>	
DATE <i>FEB 9 1956</i>							

BUREAU V. S.

9 FEB 9 1956

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

01478

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>245 Rodgers Forge Road</u>				STREET ADDRESS (If rural give location) <u>245 Rodgers Forge Road</u>			
3. NAME OF DECEASED (Type or Print) <u>Mrs. Marie S. Mc Call</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>February 1st 19 56</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>Aug. 26, 1893</u>	
9. AGE last birthday <u>62</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Mr. Charles Snyder</u>				14. MOTHER'S MAIDEN NAME <u>Mamie Gloyd</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>(If Yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT & ADDRESS <u>Mr. E. J. Mc Call, 245 Rodgers Forge Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
ANTECEDENT CAUSE(S) DUE TO <u>Coronary Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>on arteriosclerotic Basis</u>						8 yrs	
STATING UNDERLYING CAUSE LAST. (C) <u>2 previous Coronary - severe</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 1948</u> , to <u>Jan 1956</u> , that I last saw the deceased alive on <u>Jan 21, 1956</u> , and that death occurred at <u>2:50 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Charles F. Donnell</u> M.D. <u>2501 York Rd</u> DATE SIGNED <u>2/1/56</u> ADDRESS (Street, city, town, state) <u>Towson, Maryland</u> (State)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 4th 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Marian Cemetery</u>		LOCATION (City, town, or county) (State) <u>Towson, Maryland</u>	
24. REC'D BY REGISTRAR <u>Feb 1, 1956</u>		REGISTRAR'S SIGNATURE <u>Mark L. Ruck</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leonard J. Ruck, 5305 Harford Road #14</u>			

MARYLAND

01479
STATE DEPARTMENT OF HEALTH

1379 CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kingsville		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Kingsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Hilltop Drive		STREET ADDRESS Hilltop Drive	
3. NAME OF DECEASED (First) Mrs. Mamie (Middle) L. (Last) Mc Cann	4. DATE OF DEATH (Month) February (Day) 18th (Year) 1956		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH Nov. 26, 1876
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY at home	9. AGE last birthday 79 yrs.
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mr. Howard Streett		14. MOTHER'S MAIDEN NAME Jane Campbell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Mrs. Mildred Roeder, Hilltop Dr. Kingsville			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause Congestive Heart Failure		3 hrs.
(b) Antecedent cause(s) Hypertensive Cardiovascular Disease		10 yrs. +
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1, 1955, to Feb. 18, 1956, that I last saw the deceased alive on Feb. 18, 1956, and that death occurred at 2:00 a.m., from the causes and on the date stated above.

SIGNATURE William A. Tyson, M.D. ADDRESS Kingsville, Md. DATE SIGNED Feb. 18, 1956

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Feb. 21, 1956	NAME OF CEMETERY OR CREMATORY Waters Memorial Cemetery	LOCATION (City, town, or county) Cooptown, Maryland	(State)
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DATE REC'D BY LOCAL REG. Feb 20, 1956	REGISTRAR'S SIGNATURE H. W. Hedrick	24. FUNERAL DIRECTOR Leonard J. Ruck, 5305 Harford Road #14	ADDRESS
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MARGIN RESERVED FOR BINDING

Dr. Tyson
Kingsville, Md.
Belair Rd. at main intersection.

1510 CERTIFICATE OF DEATH

Reg. Dist. No. 48

1. PLACE OF DEATH:

COUNTY BALTIMORE

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)
TOWN FORT HOWARDLENGTH OF STAY
(in this place)
13 DaysHOSPITAL OR
INSTITUTION OR
STREET ADDRESS

50 VETERANS ADMINISTRATION HOSPITAL

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN BALTIMORE 3601-4STREET
ADDRESS (If rural give location)

1800 NORTH CALVERT STREET

3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

JOHN

O.

MC CRACKEN

4. DATE (Month)

(Day)

(Year)

OF

DEATH:

FEBRUARY 15

1956

5. SEX:

MALE

6. COLOR OR
RACE:

WHITE

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

MARRIED

8. DATE OF BIRTH:

March 18, 1895

9. AGE last birthday

60

YRS.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of
work done during most of working life,
even if retired):

Operator

10B. KIND OF BUSINESS
OR INDUSTRY:

Motion Pictures

11. BIRTHPLACE (State or foreign country):

Baltimore, Maryland

12. CITIZEN OF WHAT
COUNTRY?

U. S. A.

13. FATHER'S NAME:

George McCracken

14. MOTHER'S MAIDEN NAME:

Dora Reinich

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unk.)

Yes

(If Yes, give war or dates

of service)

WW I

16. SOCIAL SECURITY NO.

Unknown

17. INFORMANT & ADDRESS:

Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

161X

IMMEDIATE CAUSE

(A)

CARCINOMA OF LARYNX

ANTECEDENT CAUSE (S):

DUE TO

DISEASES OR CONDITIONS, IF ANY,
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST.

(B)

DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

HYPERTENSIVE CARDIOVASCULAR DISEASE

INTERVAL BETWEEN
ONSET AND DEATH

UNKNOWN

UNKNOWN

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21B. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)21C. WHERE DID (City or town)
INJURY OCCUR? (County)

(State)

21D. TIME (Month) (Day) (Year) (Hour)
OF INJURY

M.

21E. INJURY OCCURRED

While ☐ Not while ☐

at work at work

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 2, 1956, to Feb. 15, 1956

and that death occurred at 2:05 A.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

F. G. Dickey, M.D., Chief, Medical Service

M. D. VAH, FORT HOWARD, MARYLAND 2-15-56

23. BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF

2-17-56

NAME OF CEMETERY OR CREMATORY

Baltimore National Cemetery Baltimore, Maryland

(State)

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Wm. Cook-Blight, Inc., 6009 Harford Rd. Balto., Md.

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE
OFFICE OF THE ASSISTANT SECRETARY FOR PUBLIC AFFAIRS



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01481
381514
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 522 Windwood Road				d. STREET ADDRESS 522 Windwood Road			
3. NAME OF DECEASED (Type or print) Mr. Dwight I. Mc Kay				4. DATE OF DEATH Month February Day 27th Year 1956			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 25, 1887		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Self Emp. Farmer				10b. KIND OF BUSINESS OR INDUSTRY Connecticut		11. BIRTHPLACE (State or foreign country) United States	
13. FATHER'S NAME Albert L. Mc Kay				14. MOTHER'S MAIDEN NAME Elizabeth Mc Arthur			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Charles Robinson, 522 Windwood Road.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Emphysemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic bronchitis and asthma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 2-22 , 1952, to 2-27 , 1956, that I last saw the deceased alive on 2-27-56 , and that death occurred at 10.34 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5006 Roland Ave, Balto 10 Md DATE SIGNED ACTUAL SIGNATURE William G. Helfrich M.D. PHYSICIAN'S NAME (Type) William G. Helfrich, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Mar. 1, 1956		22c. NAME OF CEMETERY OR CREMATORY Brookfield Central Cem.		22d. LOCATION (City, town, or county) (State) Danbury, Connecticut	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road #14				24a. RECEIVED BY REGISTRAR DATE Feb. 29, 1956		24b. REGISTRAR'S SIGNATURE Mabel Gray	

CERTIFICATE OF DEATH

Name of Deceased Robert L. Mc Kay		Place of Birth Baltimore	
Date of Death Nov 25 1956		Place of Death 322 Winwood Road	
Age 32		Sex Male	
Race White		Marital Status Married	
Cause of Death Chronic bronchitis and asthma		Immediate Cause of Death Impoverishment	
Contributing Cause of Death Chronic bronchitis and asthma		Contributing Cause of Death Impoverishment	
Medical History Chronic bronchitis and asthma		Medical History Impoverishment	
Occupation Unemployed		Occupation Unemployed	
Education High School		Education High School	
Religion Catholic		Religion Catholic	
Signature of Physician Dr. Charles Robinson		Signature of Coroner Dr. Charles Robinson	
Signature of Registrar Dr. Charles Robinson		Signature of Registrar Dr. Charles Robinson	

BUREAU V. S.

MAR 11 1956

RECEIVED

1512 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Calvert	
CITY (If outside corporate limits, write RURAL or and give nearest town) 52 Catonsville		LENGTH OF STAY (in this place) 4 years		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 04X-2 Mt. Wilson			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hospital				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) George W. Monnett				4. DATE (Month) (Day) (Year) OF DEATH: Feb. 25 19 56			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single	8. DATE OF BIRTH: Jan. 5, 1880	9. AGE last birthday 76 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Odd Jobs		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: Charles Monnett				14. MOTHER'S MAIDEN NAME: Catherine Boyd			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: Records: Spring Grove State Hospital			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 420.1 Acute myocardial infarction						4 hours	
ANTECEDENT CAUSE (B) Arteriosclerotic coronary thrombosis						?	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Generalized arteriosclerosis						years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2-15-56 , 1953 to 2-25-56 , 1956, that I last saw the deceased alive on 2-25-56 , 1956, and that death occurred at 9:00 AM , from the causes and on the date stated above.							
SIGNATURE Harold E. Edler		M. D. Spring Grove Hospital		DATE SIGNED 2-25-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		DATE THEREOF Feb. 28, 1956		NAME OF CEMETERY OR CREMATORY SPRING GROVE STATE HOSP.		LOCATION (City, town, or county) (State) Catonsville 28, Maryland	
DATE REC'D BY LOCAL REGISTRAR 2/29/56		REGISTRAR'S SIGNATURE V.E. [Signature]		24. FUNERAL DIRECTOR SPRING GROVE STATE HOSPITAL - Catonsville 28, Maryland		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 29 1956

RECEIVED

1513 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City</u>	<u>3401-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Coton Ridge Nursing Home</u> <u>Harlem Lane</u>		STREET ADDRESS (If rural give location) <u>2568-W. Fairmount Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Hattie</u> <u>-</u> <u>MEYER</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>Feb. 2-1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed Aug. 3, 1876</u>	8. DATE OF BIRTH: <u>79</u> -yrs. Months Days Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>At Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY: <u>USA</u>	
13. FATHER'S NAME: <u>Ward</u>		14. MOTHER'S MAIDEN NAME: <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>?</u>	
17. INFORMANT'S ADDRESS: <u>Marrie Smith - 2568-W. Fairmount Ave.</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Broncho pneumonia</u>		<u>1 week</u>
Antecedent causes (s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.		
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: <u>Chronic salivary gland (2) ascending parotitis</u>	
19a. DATE OF OPERATION: <u>?</u>	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from May, 1955, to Feb. 2, 1956, that I last saw the deceased alive on Feb. 2, 1956, and that death occurred at 10:30 P.M. from the causes and on the date stated above.

SIGNATURE Witt Rouse (Degree or title) ADDRESS 4605 Edgewood Ave. 2/3/56 DATE SIGNED 2/3/56

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATOR	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Feb. 6, 1956</u>	<u>London Park Cem.</u>	<u>Baltimore</u>	<u>Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	FEDERAL DIRECTOR	ADDRESS	
<u>2/6/56</u>	<u>A. A. Hedrich</u>	<u>H. B. Hyslop</u>	<u>1300 Eutaw Place</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10-10-10

10-10-10

10-10-10



MARYLAND STATE DEPARTMENT OF HEALTH

01484

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 30

1514

1. PLACE OF DEATH - COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE MD COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
TOWN Catonsville		TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring Grove State Hosp.		STREET ADDRESS (If rural, give location) 430 Sanders St.	
3. NAME OF DECEASED (Type or Print)	(First) Raymond	(Middle) P.	(Last) Michael
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Apr 15 '98
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seaman		10b. KIND OF BUSINESS OR INDUSTRY Merch Marine	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME V. William Michael		14. MOTHER'S MAIDEN NAME Mrs Margaret Marburger	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		17. INFORMANT AND ADDRESS Records: Spring Grove State Hospital	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) **Congestive heart failure**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **Regurgitated food in bronchus**

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.**Tumor fourth ventricle**

?

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>	PLACE (Home, farm, factory, street, OF office bldg., etc.) Hospital	(CITY OR TOWN) Catonsville	(COUNTY) Baltimore	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY 2/17/56 4:30 pm	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? Regurgitated food during meal		

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

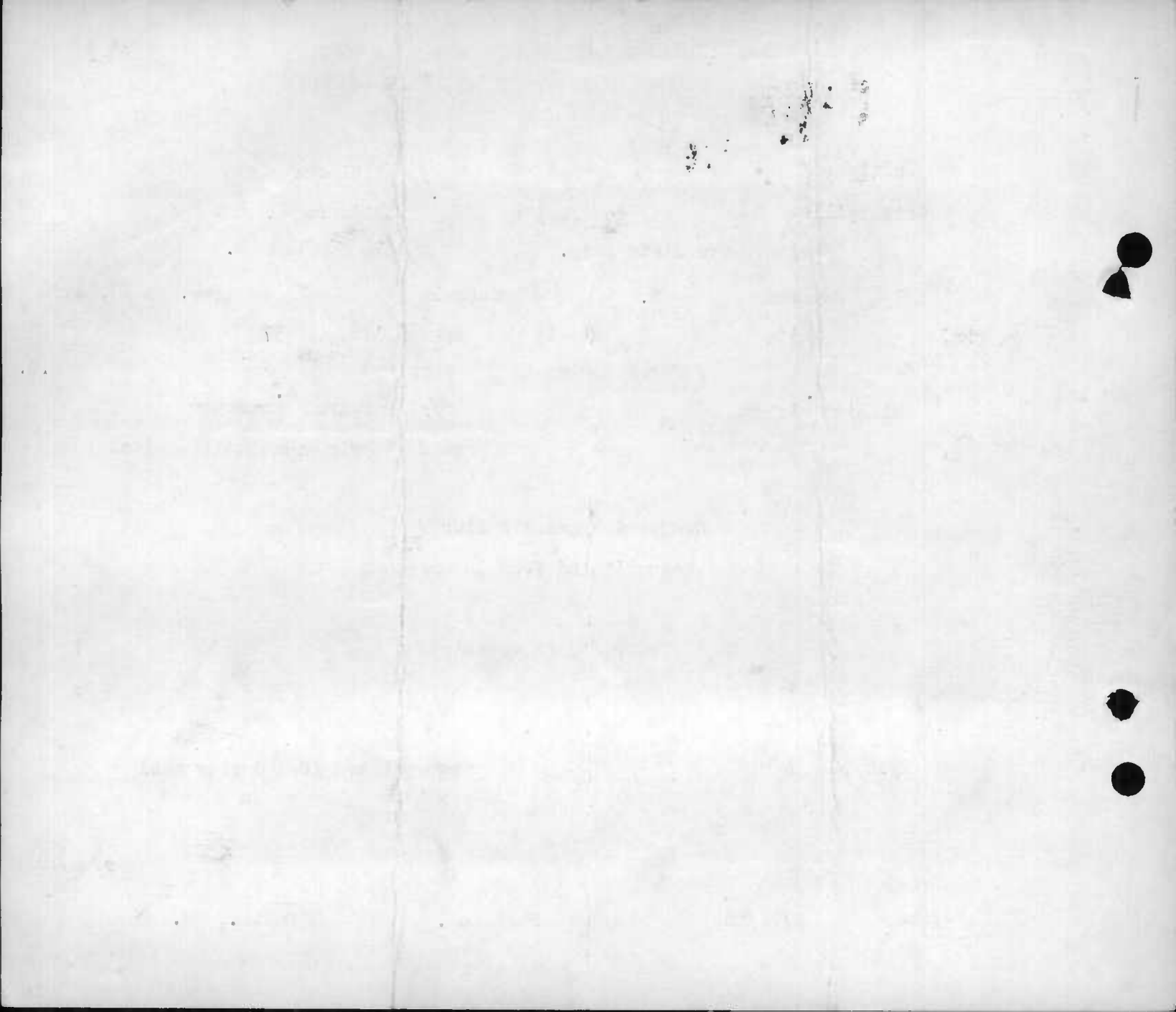
ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF 2/21/56	NAME OF CEMETERY OR CREMATORY Louisa Park Cem.	LOCATION (City, town, or county) Baltimore, Md.	(State)
DATE REC'D BY LOCAL REG Feb 20 1956	REGISTRAR'S SIGNATURE G. W. Hedrick	24. FUNERAL DIRECTOR J. L. Lickner & Sons - Balto	ADDRESS 17, Md	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1515

CERTIFICATE OF DEATH

Reg. Dist. No. 43

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baito</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Baito</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Baito Co md</u>		<u>50 yrs</u>		TOWN <u>Baito Co md</u>		X	
HOSPITAL DR INSTITUTION OR STREET ADDRESS <u>4306 Kenwood Ave</u>				STREET ADDRESS (If rural give location) <u>4306 Kenwood Ave</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Auguste S. Micklich</u>				OF DEATH: <u>Feb 3</u> 19 <u>56</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify):		8. DATE OF BIRTH:	
<u>Female</u>		<u>White</u>		<u>married</u>		<u>Oct 2-1970</u>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS		IF UNDER 1 YEAR	
<u>85 yrs.</u>		Months		Days		Hours	
						Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:			
<u>Housewife</u>				<u>At Home</u>			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<u>Germany</u>				<u>U.S.A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Conrad Fischer</u>				<u>Johanna Vaeger</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.			
<u>NO</u>				<u>NO</u>			
17. INFORMANT & ADDRESS:							
<u>Mr Karl Gabel 2605 Brundage Ave</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>2 hours</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerotic Cardiovascular Disease.</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June</u> , 1947, to <u>Feb 3</u> , 1956, that I last saw the deceased alive on <u>Feb 2</u> , 1956, and that death occurred at <u>9:35 p.m.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>May R. English</u>		<u>5713 Belair Rd</u>		<u>2-656</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/7/56</u>		<u>Parkwood Cen</u>		<u>Baito md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Feb. 6-1956</u>		<u>Mrs. M. D. Reifensh</u>		<u>Lasschen Funeral Home</u>		<u>7401 Belair Rd.</u>	

Dr English.

8-14

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BUREAU V. S.

FEB 8 1936

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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01486

1516

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY			
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 LATONSVILLE</u>		LENGTH OF STAY (in this place) <u>30 days</u>		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 House in The Pines</u>		NORTHING HOME		STREET ADDRESS (If rural give location) <u>605. MONASTERY AVE.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>MARY C. MILLER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 27 1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>AUG. 17, 1906</u>	9. AGE last birthday <u>49</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTO. MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM M. MILLER</u>				14. MOTHER'S MAIDEN NAME <u>AMANDA ELEN MCCOMAS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-07-1712</u>		17. INFORMANT & ADDRESS <u>MR. GEO. P. MILLER 605 MONASTERY AVE. (29)</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>General Carcinomatosis</u>			
154X IMMEDIATE CAUSE (A)				<u>Carcinoma of Rectum</u>			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/19</u>, 19<u>55</u>, to <u>2/27</u>, 19<u>56</u>, that I last saw the deceased alive on <u>2/25</u>, 19<u>56</u>, and that death occurred at <u>1:15 P.M.</u>, from the causes and on the date stated above.							
SIGNATURE <u>E. L. W. Schumacher</u>				ADDRESS (Street, city, town, state) <u>3432 Dresden Ave. BALTO. MARYLAND</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				DATE THEREOF <u>3/1/56</u>		NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK CEM.</u>	
24. REC'D BY REGISTRAR <u>FEB 29 1956</u>		REGISTRAR'S SIGNATURE <u>J. E. Harvey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. L. W. Schumacher</u>		ADDRESS <u>3512 Frederick Ave. (29)</u>	

CERTIFICATE OF DEATH

1936

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Race

7. Occupation

8. Cause of death

9. Date of death

10. Place of death

11. Signature of physician

12. Signature of registrar

13. Signature of witness

14. Signature of witness

15. Signature of witness

16. Signature of witness

17. Signature of witness

18. Signature of witness

19. Signature of witness

20. Signature of witness

BUREAU V. S.

FEB 29 1936

RECEIVED

ENCLOSURE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

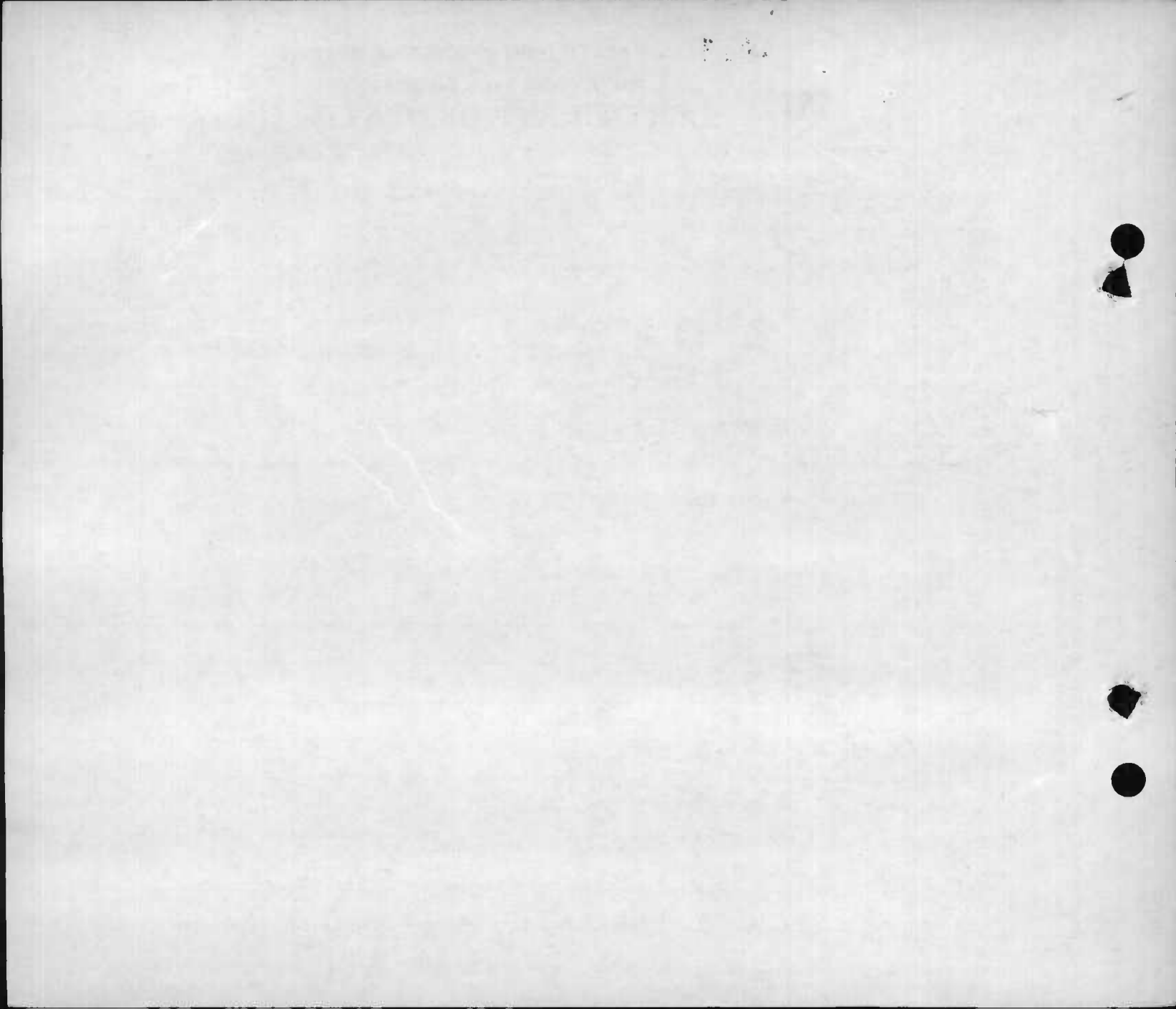
1517

01487

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>New York</u> COUNTY <u>N. Y.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>35 Marion St. Brooklyn</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>William Henry Mills</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>2</u> <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>10/21/1917</u>
9. AGE last birthday <u>38</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Book Binding</u>	
11. BIRTHPLACE (State or foreign country) <u>Durham N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Fred Mills</u>		14. MOTHER'S MAIDEN NAME <u>Vallie Weaver</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>W H</u>		16. SOCIAL SECURITY NO. <u>242-30-6375</u>	
17. INFORMANT AND ADDRESS <u>Cardell Mills 35 Marion St Brooklyn</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Fracture of Skull 20 lb</u>			<u>2 Min</u>
Antecedent cause(s) (b) <u>Auto Accident</u>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>		(STATE)	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I <u>inspected</u> the deceased <u>2-9-58</u> at <u>6:30 AM</u> that I last saw the deceased <u>alive on</u> <u>10</u> , and that death occurred at <u>6:30</u> m., from <u>the</u> causes and on the date stated above.			
SIGNATURE <u>Dr. H. H. Evans</u>		DATE SIGNED <u>2-9-58</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2/11/58</u>	
NAME OF CEMETERY OR CREMATORY <u>Long Island National Cem. Long Island N. Y.</u>		LOCATION (City, town, or county) (State) <u>N. Y.</u>	
DATE RECD BY LOCAL REG. <u>2/9/58</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	
24. FUNERAL DIRECTOR <u>1631 Bond Hill Ave.</u>		ADDRESS	



1518

CERTIFICATE OF DEATH

Reg. Dist. No.

35

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Hall		c. LENGTH OF STAY IN 1b 25 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hunters Mill Rd.		d. STREET ADDRESS Hunters Mill Rd.	
3. NAME OF DECEASED (Type or print) First Sarah Middle Elizabeth Last Powell Molock		4. DATE OF DEATH Month 2-28-56 Day 19 Year 19	
5. SEX female	6. COLOR OR RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-7-1879
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR: Months 77 Days 77 Hours 77 Min. 77	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isaac		14. MOTHER'S MAIDEN NAME Laura ??	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Howard Molock, White Hall Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Phrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Senility DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH a few hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 50 19 50 to Feb 28 19 56 that I last saw the deceased alive on Feb. 23 19 56 , and that death occurred at 3 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter Bortner M.D.		ADDRESS (Street, city or town, state) White Hall Md. DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3-3-56	22c. NAME OF CEMETERY OR CREMATORY Stephenson A.M.F.	22d. LOCATION (City, town, or county) (State) Sparks, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Scott Brooks		ADDRESS Sparks, Md.	24a. REC'D BY REGISTRAR DATE 3-6-56
		24b. REGISTRAR'S SIGNATURE Annate W. Markline	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS, COUNTY OF DALLAS, ss. I, _____, Clerk of the County Court, do hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County Court of the County of Dallas, State of Texas.

CONTENTS

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

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BUREAU V. S.

MAR 8 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01489

1519 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> TOWN <u>TOWSON</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8411 LOCH RAVEN BLVD.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD.</u> COUNTY <u>BALTO.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u> TOWN <u>TOWSON</u> STREET ADDRESS (If rural, give location) <u>8411 LOCH RAVEN BLVD.</u>	
3. NAME OF DECEASED (Type or Print) <u>ROSE</u> (First) <u>ALBERT</u> (Middle) <u>MUELLER</u> (Last)		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>6</u> (Year) <u>1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>NOV. 22, 1879</u>
9. AGE last birthday <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>FRANCIS ALBERT</u>		14. MOTHER'S MAIDEN NAME <u>MADELINE WHISTLE</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No or unk.) <u>NO</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT & ADDRESS <u>MRS. WM. A. BOWLING</u> <u>8411 LOCH RAVEN BLVD.</u>		18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis.</u></u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. INTERVAL BETWEEN ONSET AND DEATH	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2/6/56</u> , 19 <u>56</u> , to <u>2/7/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/6/56</u> , 19 <u>56</u> , and that death occurred at <u>3:30</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Denis J. McGrath</u>		ADDRESS (Street, city, town, state) <u>8358 Loch Raven Pk</u>	
DATE SIGNED <u>2/7/56</u>		M.D. <u>58358</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2/8/56</u>	
NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE MD.</u>	
24. REC'D BY REGISTRAR <u>FEB 9 1956</u>		REGISTRAR'S SIGNATURE <u>Michael Gray</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. Jenkins & Co</u>		ADDRESS <u>4905 YORK RD.</u>	

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1520

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Ridderwood Md</u>				TOWN <u>Baltimore</u> 3401-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>Sorenson Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>537 N 17th St</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>ELIZABETH R. Murphy</u>				<u>Feb 7 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widow Dec</u>	<u>1876</u>	<u>79</u>	yrs.	Months	Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>House wife</u>				<u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Patrick Doyle</u>				<u>Bridget Kiernan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: 17. INFORMANT & ADDRESS:			
				<u>Catherine Elliott 5304 Barbara St.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a) DUE TO

450.0 generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

sev. mos.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 8-10, 1955, to 2-7-, 1956, that I last saw the deceased alive on 2-1-, 1956, and that death occurred at 2:00 A., from the causes and on the date stated above.

SIGNATURE <u>E. Ellworth Cook</u>	(DEGREE OR TITLE) <u>M.D.</u>	ADDRESS <u>2432 MARYLAND AVENUE</u>	DATE SIGNED <u>2-8-56</u>
23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF <u>2-10-56</u>	NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem</u>	LOCATION (City, town, or county) (State) <u>Baltimore city Md</u>
DATE REC'D BY LOCAL REG <u>Feb 8, 1956</u>	REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Frank W. Seitz 814 W 36th St</u>	

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1134513A 1134513A

10/2/20

Arthur Tappan

W. A. R. 1000

2-10-28 Collected from

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01491

1521 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lwyn Oak</u>		LENGTH OF STAY (in this place) <u>17 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville Balto Co</u>		OR TOWN <u>Balto Co</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Allegsbury Home</u>				STREET ADDRESS (If rural give location) <u>Lutherville Balto Co</u>			
3. NAME OF DECEASED: (Type or Print) <u>Georgia</u> (First) <u>Musgrove</u> (Middle) <u>Musgrove</u> (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>2</u> <u>19</u> <u>1956</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>2/8/1860</u>	9. AGE last birthday: <u>96</u> yrs	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>Balto Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>—</u>	
13. FATHER'S NAME: <u>Geo Todd</u>				14. MOTHER'S MAIDEN NAME: <u>Jane Mayer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> (If Yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>Records Allegsbury Home</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
4220.0 IMMEDIATE CAUSE		(A) <u>Arterio - Sclerotic - Heart</u>				5 yrs.	
ANTECEDENT CAUSE (S)		DUE TO					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>Dissection - c. Arterio</u>					
		DUE TO					
		(C) <u>7th rib fracture</u>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Generalized Arterio - Sclerosis</u>						8 yrs.	
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/7</u> , 19 <u>50</u> , to <u>Feb. 19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 16</u> , 19 <u>56</u> , and that death occurred at <u>M. from the causes and on the date stated above.</u>							
SIGNATURE <u>Paul L. Chambers</u>		M. D. <u>4108 Liberty St. Baltimore</u>		DATE SIGNED <u>2/20/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2/22/56</u>		NAME OF CEMETERY OR CREMATORY <u>Carroll Mt.</u>		LOCATION (City, town, or county) (State) <u>Balto Co</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 24, 1956</u>		REGISTRAR'S SIGNATURE <u>G. W. Hedrich</u>		24. FUNERAL DIRECTOR <u>Paul Delemann</u>		ADDRESS <u>6067 Harford Rd</u>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01492

1522 CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>Rural--White Hall</u>		<u>1 yr.</u>		TOWN <u>Rural--White Hall</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JUDITH A. PARDEW</u>				<u>FEB. 13, 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH		9. AGE last birthday	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
<u>F</u>	<u>Wh.</u>	<u>Wid.</u>	<u>Aug. 12, 1868</u>		<u>87</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Home (Housewife)</u>		<u>none</u>		<u>N.C.</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Elliott Welborn</u>				<u>Nancy Snow</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>		<u>None</u>		<u>W.E. Pardew, White Hall, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
<u>422-1</u>						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>CEREBRAL HEMORRHAGE</u>						<u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Chr. Cardio-vascular Disease</u>							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Lupus erythematosus</u>						<u>?</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 31, 1956</u> , to <u>Feb. 13, 1956</u> , that I last saw the deceased alive on <u>2-12-56</u> , 19, and that death occurred at <u>10 a.m.</u> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Willard P. Hudson</u> M.D.				<u>Forest Hill, Md.</u>		<u>2-14-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 17, 1956</u>		<u>State Road</u>		<u>State Road, Surry, N.C.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS			
DATE <u>2-16-56</u>		<u>Mrs Howard S. Marklin</u>		<u>Howard K. McComas & Son, Abingdon, Md.,</u>			

RECEIVED
FEB 20 1964
BUREAU

FEB 20

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01493

1523

CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Balto.</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <i>Monkton</i>		<i>64 yrs</i>		TOWN <i>Monkton</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Carroll Road</i>				STREET ADDRESS (If rural give location) <i>Carroll Road</i>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <i>Estelle</i> (Middle) <i>Hutchins</i> (Last) <i>Pearce</i>				(Month) <i>Feb</i> (Day) <i>5</i> (Year) <i>1956</i>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<i>Female</i>	<i>White</i>	<i>Widowed</i>	<i>5 December 1870</i>	<i>85</i> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>Housewife</i>		<i>-</i>		<i>Taylor Balto Co. Md.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<i>John Slade Hutchins</i>				<i>Mary Jane Hawkins</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<i>No</i>		<i>-</i>		<i>Jacob M. Pearce Monkton, Md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <i>Cardiac Decompensation</i>						INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>	
ANTECEDENT CAUSE(S) DUE TO (B) <i>Arterio-sclerotic cardiovascular disease</i>						<i>OVER 5 yrs</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>1950</i>, to <i>Feb</i>, 19<i>56</i>, that I last saw the deceased alive on <i>3 Feb</i>, 19<i>56</i>, and that death occurred at <i>11A</i> M, from the causes and on the date stated above.							
SIGNATURE <i>Walter H. Lees</i>				ADDRESS (Street, city, town, state) <i>Cockeysville</i>		DATE SIGNED <i>5 Feb. 1956</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				DATE THEREOF <i>Feb 7-1956</i>		NAME OF CEMETERY OR CREMATORY <i>St. James</i>	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE <i>Mrs Howard S. Markline</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>Martin G. Hunt</i>	
DATE <i>2-8-56</i>				ADDRESS <i>700</i>			

CERTIFICATE OF DEATH

REG. DIV. 144

1. DECEASED'S NAME (Print or Write)

2. SEX (Print or Write)

3. AGE (Print or Write)

4. DATE OF DEATH (Print or Write)

5. PLACE OF DEATH (Print or Write)

6. TIME OF DEATH (Print or Write)

7. CAUSE OF DEATH (Print or Write)

8. MANNER OF DEATH (Print or Write)

9. SIGNATURE OF DECEASED (Print or Write)

10. SIGNATURE OF WITNESS (Print or Write)

11. SIGNATURE OF PHYSICIAN (Print or Write)

12. SIGNATURE OF CORONER (Print or Write)

13. SIGNATURE OF JURY (Print or Write)

14. SIGNATURE OF JUDGE (Print or Write)

15. SIGNATURE OF CLERK (Print or Write)

16. SIGNATURE OF REGISTRAR (Print or Write)

17. SIGNATURE OF DECEASED'S NEXT OF KIN (Print or Write)

18. SIGNATURE OF DECEASED'S ATTORNEY (Print or Write)

19. SIGNATURE OF DECEASED'S FRIEND (Print or Write)

20. SIGNATURE OF DECEASED'S NEIGHBOR (Print or Write)

21. SIGNATURE OF DECEASED'S RELATIVE (Print or Write)

22. SIGNATURE OF DECEASED'S FRIEND (Print or Write)

BUREAU V. S.

FEB 29 1956

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT IT IS CORRECTLY FILLED OUT AND THAT IT IS NOT USED FOR ANY OTHER PURPOSE.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01495

1525

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Loch Raven (Phoenix PO)</u>		<u>Life</u>		TOWN <u>Loch Raven (Phoenix P.O.)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dulaney Valley Road</u>				STREET ADDRESS (If rural give location) <u>Dulaney Valley Road</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>WILLIAM EDWARD PEERCE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>February 7, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>March, 1880</u>	9. AGE last birthday <u>75</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer-ret.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self employed</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward S. Pearce</u>				14. MOTHER'S MAIDEN NAME <u>Laura Pearce</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Family Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
163x IMMEDIATE CAUSE (A) <u>carcinoma of the lung</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION <u>X</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>home - no accident</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>no injury</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>X</u>			
22. I hereby certify that I attended the deceased from <u>11/28/56</u> , 19....., to <u>2/7/56</u> , 19....., that I last saw the deceased alive on <u>1/7/56</u> , 19....., and that death occurred at <u>9:33 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> ADDRESS (Street, city, town, state) <u>-1205 N. Calvert St. - Baltimore, Md.</u> DATE SIGNED <u>2/9/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 10, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Trinity Episcopal Cemetery</u>		LOCATION (City, town, or county) (State) <u>Long Green, Balto. Co., Md.</u>	
24. REC'D BY REGISTRAR <u>FEB 10 1956</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Towson, Maryland</u>	

CERTIFICATE OF DEATH

1955

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

01190

DATE OF DEATH

PLACE OF DEATH

DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

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BUREAU V. S.

FEB 10 1956

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INSTRUCTIONS

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TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01496

1526 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY BALTO. CO.		MARYLAND		STATE MD		COUNTY A.A.	
CITY (If outside corporate limits, write RURAL and give nearest town) 52 CATONSVILLE		LENGTH OF STAY (In this place) 8 DAYS		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PRASADENA 02X-2			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 WAYNE CONV. HOME				STREET ADDRESS 9 HARBOR RD. BAKSIDE ✓			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) MARGARET K. PEPPLER				4. DATE OF DEATH (Month) (Day) (Year) 2/13/56 19			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH 3/20/86	9. AGE last birthday 69 yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frederick Bauer				14. MOTHER'S MAIDEN NAME Anna Kahn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Raymond J. Harris			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A) Cerebral Hemorrhage						2 weeks	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO				Hypertensive C.V.D.			
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 5:24 P.M., 1956, to Feb 13, 1956, that I last saw the deceased alive on Feb 13, 1956, and that death occurred at 8:15 P.M. from the causes and on the date stated above.							
SIGNATURE J. D. Harris M.D.				ADDRESS (Street, city, town, state) 3325 Frederick Ave		DATE SIGNED 2/13/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2/16/56		NAME OF CEMETERY OR CREMATORY Gorraine		LOCATION (City, town, or county) (State) Balto. Co.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE U.E. Harry		25. FUNERAL DIRECTOR'S SIGNATURE J. Mac Nab + Son		ADDRESS	
DATE 2-16-56							

100 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

01528

Page One of Two

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF DECEASED

16. SIGNATURE OF NEXT OF KIN

17. SIGNATURE OF CLERGYMAN

18. SIGNATURE OF BURIAL OFFICIAL

19. SIGNATURE OF FUNERAL HOME

20. SIGNATURE OF CEMETERY

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF INTERVIEWER

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29. SIGNATURE OF INTERVIEWER

30. SIGNATURE OF INTERVIEWER

BUREAU V. E.

FEB 17 1956

RECEIVED

RECEIVED

1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. CAUSE OF DEATH
8. MANNER OF DEATH
9. PLACE OF DEATH
10. DATE OF DEATH
11. TIME OF DEATH
12. SIGNATURE OF PHYSICIAN
13. SIGNATURE OF REGISTRAR
14. SIGNATURE OF WITNESSES
15. SIGNATURE OF DECEASED
16. SIGNATURE OF NEXT OF KIN
17. SIGNATURE OF CLERGYMAN
18. SIGNATURE OF BURIAL OFFICIAL
19. SIGNATURE OF FUNERAL HOME
20. SIGNATURE OF CEMETERY
21. SIGNATURE OF INTERVIEWER
22. SIGNATURE OF INTERVIEWER
23. SIGNATURE OF INTERVIEWER
24. SIGNATURE OF INTERVIEWER
25. SIGNATURE OF INTERVIEWER
26. SIGNATURE OF INTERVIEWER
27. SIGNATURE OF INTERVIEWER
28. SIGNATURE OF INTERVIEWER
29. SIGNATURE OF INTERVIEWER
30. SIGNATURE OF INTERVIEWER

1527 CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY Balt.
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN FORT HOWARD	LENGTH OF STAY (in this place) 20 Hours	CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN BALTIMORE	6
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50 VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) 7935 DELROSE AVENUE	1
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
(First) WILLIAM	(Middle) C.	(Last) PFEIFFER	(Month) FEBRUARY (Day) 16 (Year) 19 56
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: December 10, 1877
9. AGE last birthday: 78 yrs.		10. AGE last birthday: 78 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Seaman		10B. KIND OF BUSINESS OR INDUSTRY: Banana Boat	
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: Charles Pfeiffer		14. MOTHER'S MAIDEN NAME: Minnie Bartz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) P. I.		16. SOCIAL SECURITY NO. 220-07-8762	
17. INFORMANT & ADDRESS: Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) DIFFUSE MYOCARDIAL FIBROSIS WITH MURAL		UNKNOWN	
ANTECEDENT CAUSE (S) THROMBI, LEFT VENTRICLE		UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. DUE TO CORONARY ARTERIOSCLEROSIS			
(C) LOBULAR PNEUMONIA			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb. 15, 19 56 to Feb. 16, 19 56 and that death occurred at 7:30 A.M. from the causes and on the date stated above.			
SIGNATURE D. D. MARK, M.D.		DATE SIGNED 2-17-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2-20-56	
NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		LOCATION (City, town, or county) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR Feb 20, 1956		REGISTRAR'S SIGNATURE Wm. Cook-Blight, Inc.	
24. FUNERAL DIRECTOR ADDRESS 6009 Harford Rd., Balto.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

• • • • •

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1528

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN FORT HOWARD	59 Days	TOWN BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) 2128 ORLEANS STREET	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
STANISLAW POLSKI		DEATH FEBRUARY 9 1956	
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify) MARRIED	8. DATE OF BIRTH: April 18, 1892
9. AGE last birthday 63 yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer		10B. KIND OF BUSINESS OR INDUSTRY: Cemetery	
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: Valanty Polski		14. MOTHER'S MAIDEN NAME: Mary Konikowska	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) WW I		16. SOCIAL SECURITY No. 214-10-0191	
17. INFORMANT & ADDRESS: Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) ADENOCARCINOMA, RECTUM		1 YEAR
ANTECEDENT CAUSE (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: 8/16/55		19B. MAJOR FINDINGS OF OPERATION: Transverse Colostomy		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Dec. 12, 1955 , to Feb. 9, 1956 , and that death occurred at 2:45 PM , from the causes and on the date stated above.					
SIGNATURE Irving Freeman		ADDRESS M. D. VAH, FORT HOWARD, MARYLAND		DATE SIGNED 2/9/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb 13, 1956		LOCATION (City, town, or county) (State) Holy Redeemer Cemetery Balto. Md.	
DATE REC'D BY LOCAL REGISTRAR February 11, 1956		REGISTRAR'S SIGNATURE R.W.		24. FUNERAL DIRECTOR ADDRESS Billy & Zeilen Inc., Fun. Dir. 1901 Eastern Av. Balto. Md.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01499

1529

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
52 TOWN <u>CATONSVILLE</u>		6 Mos		28 MELROSE AVE		52	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
90 <u>HOUSE IN PINES</u>				<u>CATONSVILLE</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>MABEL A. PORTER</u>				<u>2/18/56</u> 19			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>SINGLE</u>	<u>3/10/1880</u>	<u>75</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Clk</u>		<u>office</u>		<u>Net.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>James Porter</u>				<u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)				<u>Hosp. records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
416X IMMEDIATE CAUSE (A) <u>Broncho-Pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>Myocardial Decompensation</u>						<u>10 da.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Chronic Rheumatic Heart Disease</u>						<u>3 mo</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>20 yrs (?)</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
0							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-19</u> , 19 <u>55</u> , to <u>2-18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-18</u> , 19 <u>56</u> , and that death occurred at <u>7:45 P.</u> M, from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>William K. Gallagher</u>				<u>M.D. Catonsville-28, Md.</u>		<u>2-20-56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/21/56</u>		<u>Landon Park</u>		<u>Balto Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>2/21/56</u>		<u>T.E. Harry</u>		<u>MacIntosh</u>		<u>28</u>	

01303

MAR/1956 STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

CERTIFICATE OF DEATH

1823

1. NAME OF DECEASED

2. PLACE OF DEATH

3. DATE OF DEATH

4. TIME OF DEATH

5. CAUSE OF DEATH

6. MANNER OF DEATH

7. PLACE OF BIRTH

8. DATE OF BIRTH

9. SEX

10. RACE

11. OCCUPATION

12. MARITAL STATUS

13. EDUCATION

14. RELIGION

15. SOCIAL SECURITY NUMBER

16. SIGNATURE OF DECEASED

17. SIGNATURE OF WITNESS

18. SIGNATURE OF PHYSICIAN

19. SIGNATURE OF CORONER

20. SIGNATURE OF JUDGE

21. SIGNATURE OF CLERK

22. SIGNATURE OF REGISTRAR

23. SIGNATURE OF VENDOR

24. SIGNATURE OF TAXPAYER

25. SIGNATURE OF SELLER

26. SIGNATURE OF BUYER

27. SIGNATURE OF LESSOR

28. SIGNATURE OF LESSEE

29. SIGNATURE OF MORTGAGOR

30. SIGNATURE OF MORTGAGEE

James Foster
Office

Hoof. record

U.S.A.

BUREAU V. S.

FEB 23 1956

RECEIVED

2/21/56
James Foster
Office

MARYLAND STATE DEPARTMENT OF HEALTH

01501

1531 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 43

1. PLACE OF DEATH- COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Owens		CITY (If outside corporate limits, write RURAL and give nearest town) Rural-Balto Md	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 6900 Belair Rd.		STREET ADDRESS (If rural, give location) 6900 Belair Rd	
3. NAME OF DECEASED (Type or Print)	(First) Bertha (Middle) Idella (Last) Punkte	4. DATE OF DEATH (Month) 2 (Day) 18 (Year) 1956	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Feb 7, 1886
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Asst. Wf.		10b. KIND OF BUSINESS OR INDUSTRY -	9. AGE last birthday 70 yrs. If under 1 year Months Days If under 24 hrs. Hours Mins.
11. BIRTHPLACE (State or foreign country) Balto Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Orice Du Val		14. MOTHER'S MAIDEN NAME Eliza Jane Townsend	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Gertrude Punkte - 4129 Martin Ave.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) Coronary Occlusion		5-10 min
Antecedent cause(s) (b) Coronary Artery disease		Sev yrs.
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Cardiac Failure - compensated		Sev yrs.
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE **John C. Gyle M.D.** (Degree or title) ADDRESS **7527 Belair Rd** DATE SIGNED **2-16-56**

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	Feb. 21, 1956	Mt. Olive M. E.	Balto. Co. Md.
DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Feb 19, 1956	Mrs. M. J. Ruffin	Lorraine Funeral Home - 7401 Belair Rd.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1456
70
986

RECEIVED
FEB 23 1956

BUREAU V. I.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1532 CERTIFICATE OF DEATH

01502

Reg. Dist. No.

Item 12, Film G192 2-10-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>53</u> TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>Parkville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5743 Edmondson Avenue</u>				STREET ADDRESS (If rural give location) <u>8310 Harford Road #14</u>			
3. NAME OF DECEASED (Type or Print) <u>Christian</u> (First) <u>Rau</u> (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>February 5th 19 56</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Jan. 15, 1884</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Tool Designer</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>August Rau</u>				14. MOTHER'S MAIDEN NAME <u>Sophia</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mr. James Kotschenreuther, 8310 Harford</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>4427</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)				<u>Hypertensive Cardiovascular renal disease</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>ANGINA PECTORIS.</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov.</u> , 19 <u>55</u> , to <u>Feb. 5</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 5</u> , 19 <u>56</u> , and that death occurred at <u>7:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. Nelson McKay</u>				ADDRESS (Street, city, town, state) <u>6014 Edmondson Ave</u>		DATE SIGNED <u>Feb. 5, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/8/1956</u>		NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>Feb. 7, 1956</u>		REGISTRAR'S SIGNATURE <u>Victor E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Leonard J. Ruck, 5305 Harford Road #14</u>			

CERTIFICATE OF DEATH

01512

Reg. Off. No.

1. DEATH OF DEATH

2. NAME OF DECEASED

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF JURY

15. SIGNATURE OF JUDGE

16. SIGNATURE OF CLERK

17. SIGNATURE OF SHERIFF

18. SIGNATURE OF DEPUTY SHERIFF

19. SIGNATURE OF CONSTABLE

20. SIGNATURE OF JAILER

21. SIGNATURE OF PRISONER

22. SIGNATURE OF GUARD

23. SIGNATURE OF WARDEN

24. SIGNATURE OF CHIEF CLERK

25. SIGNATURE OF DEPUTY CLERK

26. SIGNATURE OF RECEPTIONIST

27. SIGNATURE OF ATTORNEY

28. SIGNATURE OF PROSECUTOR

29. SIGNATURE OF DEFENSE COUNSEL

30. SIGNATURE OF JURY

31. SIGNATURE OF JUDGE

32. SIGNATURE OF CLERK

33. SIGNATURE OF SHERIFF

34. SIGNATURE OF DEPUTY SHERIFF

35. SIGNATURE OF CONSTABLE

36. SIGNATURE OF JAILER

37. SIGNATURE OF PRISONER

38. SIGNATURE OF GUARD

39. SIGNATURE OF WARDEN

40. SIGNATURE OF CHIEF CLERK

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43. SIGNATURE OF ATTORNEY

44. SIGNATURE OF PROSECUTOR

45. SIGNATURE OF DEFENSE COUNSEL

46. SIGNATURE OF JURY

47. SIGNATURE OF JUDGE

48. SIGNATURE OF CLERK

49. SIGNATURE OF SHERIFF

50. SIGNATURE OF DEPUTY SHERIFF

51. SIGNATURE OF CONSTABLE

52. SIGNATURE OF JAILER

53. SIGNATURE OF PRISONER

54. SIGNATURE OF GUARD

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57. SIGNATURE OF DEPUTY CLERK

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59. SIGNATURE OF ATTORNEY

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62. SIGNATURE OF JURY

63. SIGNATURE OF JUDGE

64. SIGNATURE OF CLERK

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67. SIGNATURE OF CONSTABLE

68. SIGNATURE OF JAILER

69. SIGNATURE OF PRISONER

70. SIGNATURE OF GUARD

71. SIGNATURE OF WARDEN

72. SIGNATURE OF CHIEF CLERK

73. SIGNATURE OF DEPUTY CLERK

74. SIGNATURE OF RECEPTIONIST

75. SIGNATURE OF ATTORNEY

76. SIGNATURE OF PROSECUTOR

77. SIGNATURE OF DEFENSE COUNSEL

78. SIGNATURE OF JURY

79. SIGNATURE OF JUDGE

80. SIGNATURE OF CLERK

81. SIGNATURE OF SHERIFF

82. SIGNATURE OF DEPUTY SHERIFF

83. SIGNATURE OF CONSTABLE

84. SIGNATURE OF JAILER

85. SIGNATURE OF PRISONER

86. SIGNATURE OF GUARD

87. SIGNATURE OF WARDEN

88. SIGNATURE OF CHIEF CLERK

89. SIGNATURE OF DEPUTY CLERK

90. SIGNATURE OF RECEPTIONIST

91. SIGNATURE OF ATTORNEY

92. SIGNATURE OF PROSECUTOR

93. SIGNATURE OF DEFENSE COUNSEL

94. SIGNATURE OF JURY

95. SIGNATURE OF JUDGE

96. SIGNATURE OF CLERK

97. SIGNATURE OF SHERIFF

98. SIGNATURE OF DEPUTY SHERIFF

99. SIGNATURE OF CONSTABLE

100. SIGNATURE OF JAILER

RECEIVED

BUREAU V. S.

FEB 8 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01503
1533 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town.)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SPARROWS POINT (19)</u>		<u>19 YRS</u>		TOWN <u>SPARROWS POINT (19)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1027 H ST.</u>				STREET ADDRESS (If rural give location) <u>1027 H ST.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>MARY HANNAH REDMOND</u>				DEATH: <u>FEB. 26, 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F.</u>	<u>W.</u>	<u>WIDOWED</u>	<u>FEB. 13, 1872</u>	<u>84.</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>HOUSEWIFE</u>				<u>NONE</u>		<u>PENNA.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>THOMAS MELVILLE</u>				<u>MARY MCCARRAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>NO</u>				<u>NONE.</u>		<u>MRS. BERTHA SIMON - WEST CHESTER PENNA.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						<u>Immediate</u>	
ANTECEDENT CAUSE (S) <u>Hypertensive Arteriosclerosis, heart failure</u>						<u>20 years.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Senility.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Bronchopneumonia</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 15, 1956</u> , to <u>February 26, 1956</u> , that I last saw the deceased alive on <u>February 24, 1956</u> , and that death occurred at <u>5 P. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>David Owens</u>		ADDRESS <u>M. D. Sparrows Point Ind.</u>		DATE SIGNED <u>2/26/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>2-29-56</u>		<u>OAK LAND</u>		<u>WEST CHESTER, PENNA.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 29, 1956</u>		REGISTRAR'S SIGNATURE <u>Dawson L. Larkins</u>		24. FUNERAL DIRECTOR <u>Walter Clarke Brundage</u>		ADDRESS <u>Randolph, Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

01504

2411 N. Charles Street, Baltimore

1534

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>West Towne</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>52</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5706 Edmonston Ave.</u>		STREET ADDRESS (If rural, give location) <u>5706 Edmonston Avenue</u>	
3. NAME OF DECEASED (Type or Print) <u>HILDA LOUISE REGAN</u>		4. DATE OF DEATH (Month) <u>2</u> (Day) <u>5</u> (Year) <u>56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	9. AGE last birthday <u>56</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Kirchner</u>		14. MOTHER'S MAIDEN NAME <u>Mary Winter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Mr. F.L.Regan-5706 Edmonston Ave</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

Carcinoma of Brain

INTERVAL BETWEEN ONSET AND DEATH

7 Months

Antecedent cause(s)

Disease or conditions, if any, giving rise to the above cause stating the underlying cause last

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

20. AUTOPSY?

Yes ☐ No ☐22. I hereby certify that I attended the deceased from 8/9, 1955, to 2/5, 1956, that I last saw the deceasedalive on 1/26, 1956, and that death occurred at 7:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Eliot W. Johnson M.D. 3432 Druid Avenue Balto. Md 2923. BURIAL, CREMATION REMOVAL (Specify)
BurialDATE THEREOF
2-8-56NAME OF CEMETERY OR CREMATORY
London ParkLOCATION (City, town, or county)
Balto. City

(State)

DATE REC'D BY LOCAL REG.
Feb 7, 1956REGISTRAR'S SIGNATURE
A. W. Hedrich

24. FUNERAL DIRECTOR

ADDRESS

Fred A. Cole1915 W. Baltimore St.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2124

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1395 CERTIFICATE OF DEATH

0150547

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>51</u> TOWN <u>Arbutus</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Arbutus</u>		<u>51</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>5514 Carville Ave</u>				STREET ADDRESS (If rural give location) <u>5514 Carville Ave</u>			
3. NAME OF DECEASED (Type or Print) <u>Tillie</u> <u>Rehling</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 26</u> <u>19 56</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Apr. 19, 1876</u>	9. AGE last birthday <u>79</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Hucksoll</u>				14. MOTHER'S MAIDEN NAME <u>Anna</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-07-3598</u>		17. INFORMANT & ADDRESS <u>Mrs Myrtle Karweick.</u> <u>5514 Carville Ave</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
443X IMMEDIATE CAUSE (A) <u>Hypertensive A.S.C. V.D.</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Terminal Uremia</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/12</u>, 19<u>53</u>, to <u>2/26</u>, 19<u>56</u>, that I last saw the deceased alive on <u>2/26</u>, 19<u>56</u>, and that death occurred at <u>2:05</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>John C. Healy</u> M.D.				ADDRESS (Street, city, town, state) <u>Baltimore, Md.</u>		DATE SIGNED <u>2/28/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Feb. 29/56</u>		NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Mar. 1, 1956</u>		REGISTRAR'S SIGNATURE <u>Dr. Geo. S. M. Luper</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harold W. Witzke</u>		ADDRESS <u>4101 Edmondson Ave</u>	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

CERTIFICATE OF DEATH

1953

MD - 12000-100

1. NAME OF DECEASED

DATE OF BIRTH

DATE OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF INTERVIEW

DATE OF REPORT

REPORTED BY

DATE OF DEATH

DATE OF INTERVIEW

DATE OF REPORT

REPORTED BY

DATE OF DEATH

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DATE OF DEATH

DATE OF INTERVIEW

DATE OF REPORT

REPORTED BY

BUREAU V. S.

MAR 1 1956

RECEIVED

1535

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X TOWN Owings Mills, Maryland

LENGTH OF STAY (in this place)

8 1/2 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS

12 Rosewood State Training School

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY City

CITY (If outside corporate limits, write RURAL and give nearest town) OR

TOWN Baltimore, Maryland3401-4

STREET ADDRESS (If rural give location)

4123 Grace Court

3. NAME OF DECEASED: (Type or Print)

(First)

(Middle)

(Last)

EvelynBeatriceRiggins

4. DATE (Month) (Day) (Year)

OF

DEATH: February 7th, 19 56

5. SEX:

female

6. COLOR OR RACE:

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

single

8. DATE OF BIRTH:

9/30/37

9. AGE last birthday

18 yrs.

IF UNDER 1 YEAR

Months

Days

IF UNDER 24 HRS.

Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

never worked

10B. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME:

Otis Brice Riggins

14. MOTHER'S MAIDEN NAME:

Evelyn Virginia Clayton

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

none

17. INFORMANT & ADDRESS:

Rosewood Records

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

7531

IMMEDIATE CAUSE

(A) Acute edema of brain with central respiratoryDUE TO cessation

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(B) Tumor 3rd Ventricle with hemorrhage

DUE TO

(C) Tuberous Sclerosis with symptomatic epilepsy

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

Tuberous sclerosis, Epilepsy, Hemiplegia, left

INTERVAL BETWEEN ONSET AND DEATH

19A. DATE OF OPERATION:

2 none

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

none

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

---M.21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

----22. I hereby certify that I attended the deceased from 2/6/, 1956, to 2/7, 1956, that I last saw the deceasedalive on 2/7/, 1956, and that death occurred at 12:10 A.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

Harry B. Butler MD.M. D. Owens Mills, Md.8 Feb 56

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

2/11/56

NAME OF CEMETERY OR CREMATORY

Fork Methodist Cem.

LOCATION (City, town, or county)

Fork, Md.

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

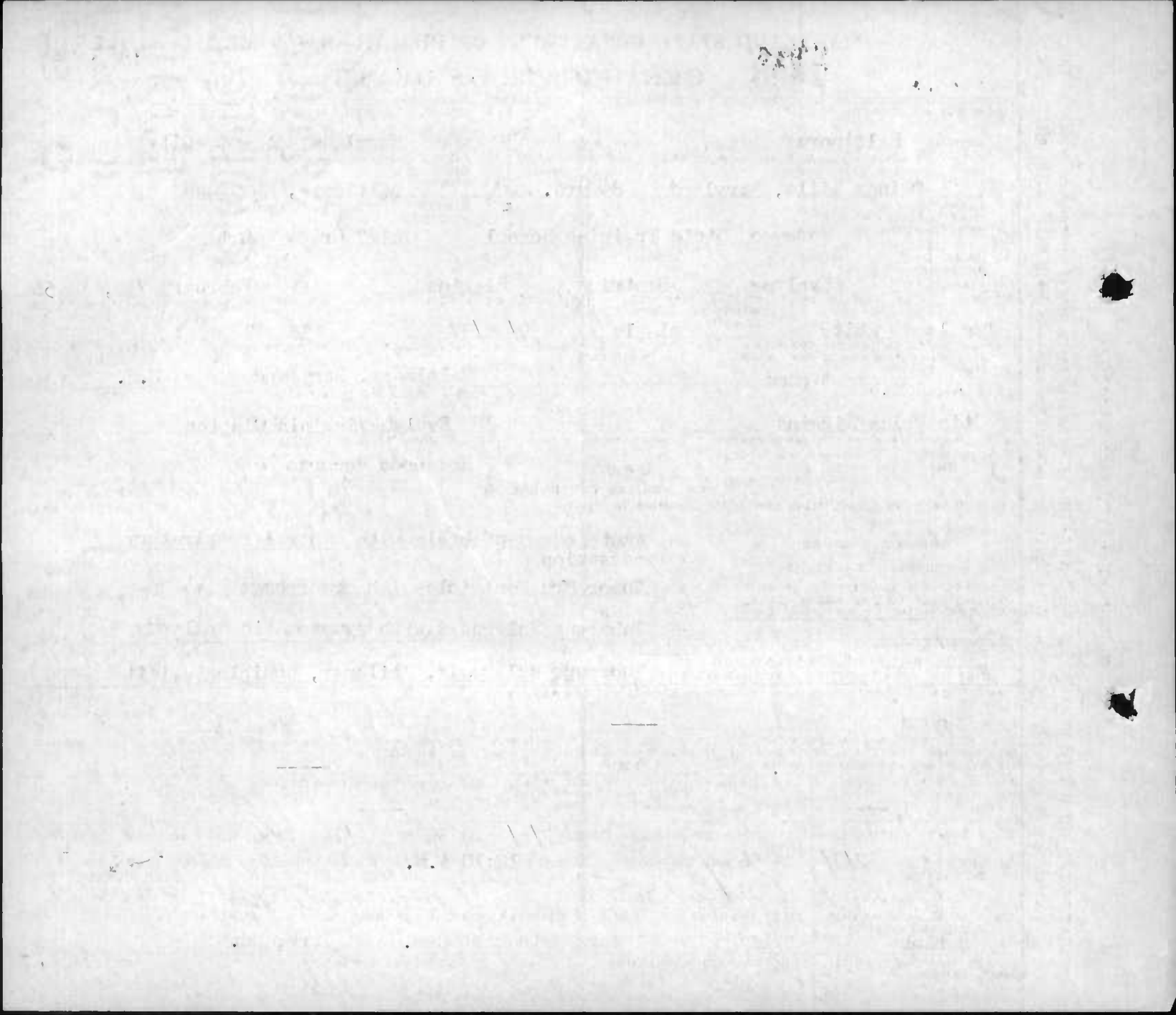
ADDRESS

Feb 7, 1956 A. H.HedrickWm. J. Lickner & Sons - Balto Md

17

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01508

1536 CERTIFICATE OF DEATH

Item 2, Film G192 2-17-56 et Item 8, Film G192 2-20-56 et

Reg. Dist. No. 32

1. PLACE OF DEATH COUNTY Balto. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN LOWSON HOSPITAL OR INSTITUTION OR STREET ADDRESS Stella Maris Hospice				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY BALTB. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN B/Towson Baltimore, 18 STREET ADDRESS 4409 Greenway Pot Spring Rd / Duane Valley			
3. NAME OF DECEASED (First) Cecilia (Middle) Riley (Last) Riley				4. DATE OF DEATH (Month) 2/8/56 (Day) 19 (Year) 19			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) S	8. DATE OF BIRTH 3/4/77 1874	9. AGE last birthday 81 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Patrick Riley				14. MOTHER'S MAIDEN NAME Ann Byrnes			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 442X IMMEDIATE CAUSE (A) Pulmonary Edema ANTECEDENT CAUSE(S) DUE TO (B) Hypertension/Coronary DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) Renal Vascular Disease STATING UNDERLYING CAUSE LAST.				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH 10 Hrs. 10 yrs.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Oct 7, 1956 , to Feb 8, 1956 , that I last saw the deceased alive on Feb 7, 1956 , and that death occurred at 1:14 P.M. from the causes and on the date stated above. SIGNATURE Charles F. O'Donnell ADDRESS (Street, city, town, state) 2561 York Rd #42nd Baltimore DATE SIGNED 2/8/56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2/11/1956		NAME OF CEMETERY OR CREMATORY Cathedral Cemetery		LOCATION (City, town, or county) (State) Baltimore Md.	
24. REC'D BY REGISTRAR DATE Feb 10, 1956		REGISTRAR'S SIGNATURE Matel Gray		25. FUNERAL DIRECTOR'S SIGNATURE Flynn Fleming		ADDRESS I426 Light St.	

01208

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

1953 CERTIFICATE OF DEATH

Form 100-100

1. FULL NAME OF DECEASED (Print or Type)

MARYLAND

DATE

2. SEX
3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH (Print or Type)

9. MANNER OF DEATH (Print or Type)

10. PLACE OF DEATH (Print or Type)

11. SIGNATURE OF PHYSICIAN (Print or Type)

12. SIGNATURE OF REGISTRAR (Print or Type)

13. MEDICAL CERTIFICATION (Print or Type)

14. SIGNATURE OF PHYSICIAN (Print or Type)

15. SIGNATURE OF REGISTRAR (Print or Type)

16. SIGNATURE OF PHYSICIAN (Print or Type)

17. SIGNATURE OF REGISTRAR (Print or Type)

18. SIGNATURE OF PHYSICIAN (Print or Type)

19. SIGNATURE OF REGISTRAR (Print or Type)

20. SIGNATURE OF PHYSICIAN (Print or Type)

21. SIGNATURE OF REGISTRAR (Print or Type)

22. SIGNATURE OF PHYSICIAN (Print or Type)

23. SIGNATURE OF REGISTRAR (Print or Type)

24. SIGNATURE OF PHYSICIAN (Print or Type)

25. SIGNATURE OF REGISTRAR (Print or Type)

26. SIGNATURE OF PHYSICIAN (Print or Type)

27. SIGNATURE OF REGISTRAR (Print or Type)

28. SIGNATURE OF PHYSICIAN (Print or Type)

29. SIGNATURE OF REGISTRAR (Print or Type)

30. SIGNATURE OF PHYSICIAN (Print or Type)

31. SIGNATURE OF REGISTRAR (Print or Type)

32. SIGNATURE OF PHYSICIAN (Print or Type)

33. SIGNATURE OF REGISTRAR (Print or Type)

34. SIGNATURE OF PHYSICIAN (Print or Type)

35. SIGNATURE OF REGISTRAR (Print or Type)

BUREAU V. S.

FEB 14 1956

RECEIVED

PHOTOCOPYED
This document is a photocopy of the original document. It is not a legal document and should not be used for legal purposes. The original document is the only one that should be used for legal purposes.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01509

1537 CERTIFICATE OF DEATH

Item 2, FilmG193 2-27-56 et

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>BALTO.</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> TOWN <u>FR</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CATONSVILLE CONV. HOME</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>BALTO.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> TOWN <u>Ellicott City</u> STREET ADDRESS <u>CATONSVILLE CONV. HOME</u>			
3. NAME OF DECEASED (Type or Print) <u>HARRY THOMAS RILEY</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>2/1/56</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>2/27/1890</u>	9. AGE last birthday <u>65</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baltimore Water Dept</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>?</u>			
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>?</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>HOSP. RECORDS</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE (A) <u>Acute pulmonary edema</u> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Left Ventric Failure; ASCVD</u> (C) <u>Unknown</u>				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>8 hrs</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>July 2</u> , 19 <u>55</u> , to <u>2-1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-31</u> , 19 <u>56</u> , and that death occurred at <u>7:30 A.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Stephen L. Magnus</u>		ADDRESS (Street, city, town, state) <u>908 Fredericka, Carmichael Md</u>		DATE SIGNED <u>2-2-56</u>			
23. BURIAL, CREMATION, REBURYAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/7/56</u>		NAME OF CEMETERY OR CREMATORY <u>Good Shepherd</u>			
24. REC'D BY REGISTRAR <u>2-5-56</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Nabbedon</u>			
DATE		ADDRESS		28			

1547

9-11 - 21112205TAS

GAZETTE OF INDIA

HARRY THOMAS 1912 FT

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HO 26. 1550002

BUREAU V. 8.

FEB 7 1956

RECEIVED

28 Mrs. M. H. + Son 27/25

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1538 CERTIFICATE OF DEATH

01510

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		STATE MARYLAND		STATE New York		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN Ruxton				TOWN Brooklyn		69x-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sorenson Nursing Home 7912 Ruxway				STREET ADDRESS (If rural give location) 517 72nd Street			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Mr. Leon S. Rivers				February 5th 19 56			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
male	white	widowed	May 7, 1875	80 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Machinist				Brooklyn, New York		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Augustus H. Rivers				Elizabeth Stevenson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)				Mrs. C. L. Sommers, 715 Hillen Road			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.0 IMMEDIATE CAUSE (A)						INTERVAL BETWEEN ONSET AND DEATH	
Arteriosclerotic heart disease						yes	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
Generalized arteriosclerosis						yes	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 31, 19 56, to Feb. 4, 19 56, that I last saw the deceased alive on Feb. 4, 19 56, and that death occurred at 12:20 A.M. from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
Ernest C Brown Jr		M.D. 1101 N. Calvert St		Feb 6, 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Feb. 7, 1956		Baltimore National Cem.		Baltimore, Maryland	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE 2/6/56		Ambediah / et		Leonard J. Ruck, 5305 Harford Road #14			

Mrs. Mabel Krayo

SMOKE-PROOF

1. The purpose of this form is to provide a means for the collection of data on the use of smokeless tobacco products. It is to be filled out by the user of the product and submitted to the nearest health department or to the nearest Federal Bureau of Investigation office. The information obtained from this form will be used for statistical purposes only and will not be made available to the public.

1958 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10

01510

Reg. Dist. No.

X SPECIAL REGISTRATION (NUMBER OF DECEASED)

<p>1. NAME OF DECEASED</p> <p>2. SEX</p> <p>3. AGE</p> <p>4. DATE OF BIRTH</p> <p>5. PLACE OF BIRTH</p> <p>6. RACE</p> <p>7. OCCUPATION</p> <p>8. MARITAL STATUS</p> <p>9. EDUCATION</p> <p>10. RELIGION</p> <p>11. PREVIOUS ILLNESS</p> <p>12. CAUSE OF DEATH</p> <p>13. PLACE OF DEATH</p> <p>14. DATE OF DEATH</p> <p>15. SIGNATURE OF DECEASED</p> <p>16. SIGNATURE OF WITNESS</p> <p>17. SIGNATURE OF PHYSICIAN</p> <p>18. SIGNATURE OF CORONER</p> <p>19. SIGNATURE OF JURY</p> <p>20. SIGNATURE OF JUDGE</p> <p>21. SIGNATURE OF CLERK</p> <p>22. SIGNATURE OF NOTARY</p> <p>23. SIGNATURE OF SHERIFF</p> <p>24. SIGNATURE OF DEPUTY SHERIFF</p> <p>25. SIGNATURE OF CONSTABLE</p> <p>26. SIGNATURE OF DEPUTY CONSTABLE</p> <p>27. SIGNATURE OF TOWNSHIP CLERK</p> <p>28. SIGNATURE OF COUNTY CLERK</p> <p>29. SIGNATURE OF STATE CLERK</p> <p>30. SIGNATURE OF FEDERAL CLERK</p>	
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BUREAU V. 3

FEB 7 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
 FOR MEDICAL EXAMINERS

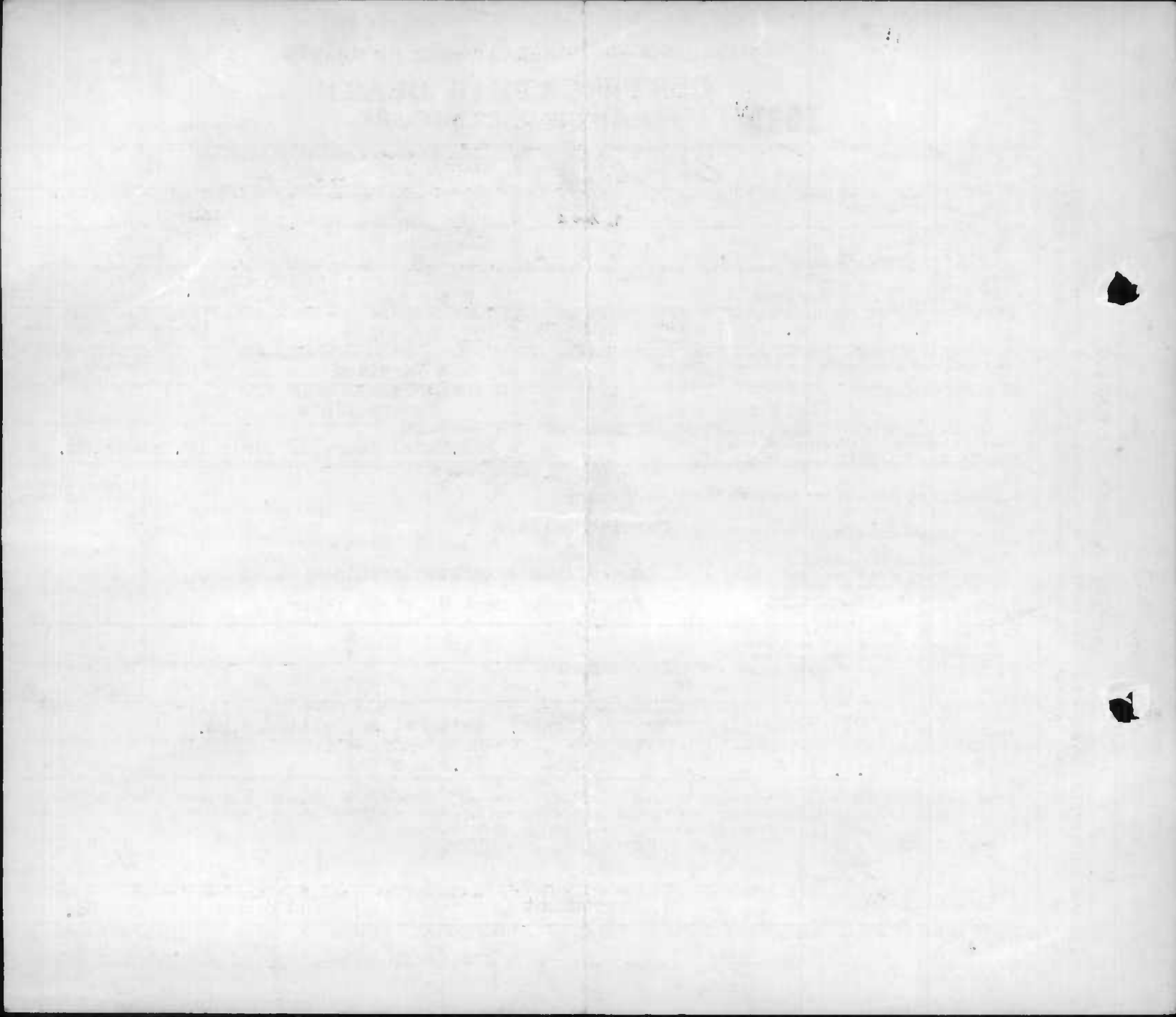
1539

01511

30

Reg. Dist. No.

1. PLACE OF DEATH— COUNTY Catonsville BALTO MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED— STATE Md COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN 14 Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore 3401-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Spring House State Hosp		STREET ADDRESS (If rural, give location) 4301 Roland Ave	
3. NAME OF DECEASED (Type or Print) L. Corinne (First) (Middle) (Last) R o c h e		4. DATE OF DEATH (Month) (Day) (Year) Febr. 22 1956	
5. SEX F.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH 11/26/1874
9. AGE last birthday 81 yrs.		10. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Roche		14. MOTHER'S MAIDEN NAME Medora Lintz	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --- (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Ethel Beary, 12 Dixie Dr. Towson, Md.			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
9047 Immediate cause (a) Cardiac Failure			
Antecedent cause(s) (b) Generalized Arteriosclerosis Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Fracture of neck of right femur			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office hldg., etc.) hospit. (CITY OR TOWN) (COUNTY) (STATE) Catonsville, Baltimore, Md.	
TIME (Month) (Day) (Year) (Hour) OF INJURY Febr. 6, 1956 m.		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> HOW DID INJURY OCCUR? Pt. had a fall	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> , accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE Dr. McKieffer		DATE SIGNED 2/22/1956	
23. BURIAL, CREMATION, REMOVAL (Specify) 2/24/56		NAME OF CEMETERY OR CREMATORY Greenmount LOCATION (City, town, or county) (State) Baltimore Md.	
DATE REC'D BY LOCAL REG. Feb 23, 1956		24. FUNERAL DIRECTOR Wm. Cook, Inc. ADDRESS 1217 St. Paul Street	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01512

1540 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS House in Pines Nursing Home		STREET ADDRESS 511 N. Streeper St.	
3. NAME OF DECEASED (First) (Middle) (Last) JULIUS CHRISTIAN ROHRBACH. Sr.		4. DATE OF DEATH (Month) (Day) (Year) Feb. 4. 1956	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH July. 19. 1880
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postoffice-Mail Clerk		10b. KIND OF BUSINESS OR INDUSTRY Retired 15 yrs	9. AGE last birthday 75 yrs
11. BIRTHPLACE (State or foreign country) Baltimore Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Wilhelm Rohrbach		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Julius Rohrbach Jr.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause (a) Coronary Thrombosis		1 hr.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Chronic Hypertensive Cardio-Vascular Disease		15 yrs.
(c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

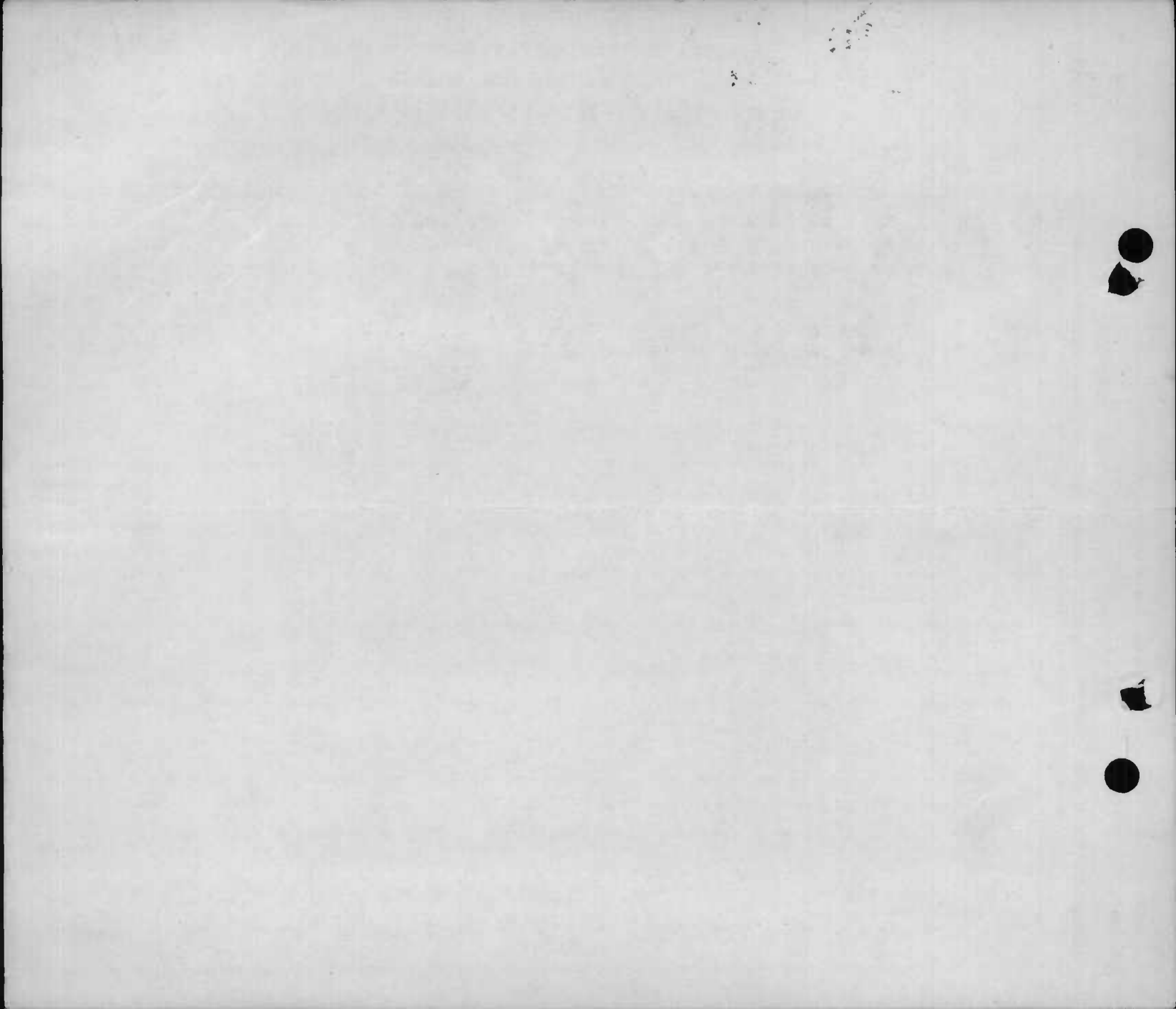
22. I hereby certify that I attended the deceased from **2-2**, 19**52**, to **2-4**, 19**56**, that I last saw the deceased alive on **2-5**, 19**56**, and that death occurred at **7:45 A.M.**, from the causes and on the date stated above.

SIGNATURE William R. Gallagher M.D.		ADDRESS 6209 Frederick Rd. Baltimore. 28 Md.		DATE SIGNED 2/5/56
23. BURIAL CREMATION REMOVAL (Specify) Burial	DATE THEREOF Feb. 7. 1956	NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	LOCATION (City, town, or county) Baltimore Md.	(State)
DATE REC'D BY LOCAL REG. Feb 6, 1956	REGISTRAR'S SIGNATURE A.W. Hedrich	24. FUNERAL DIRECTOR HENRY SANDER & SONS. INC.		ADDRESS Baltimore Md.
Henry J. Sander				

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



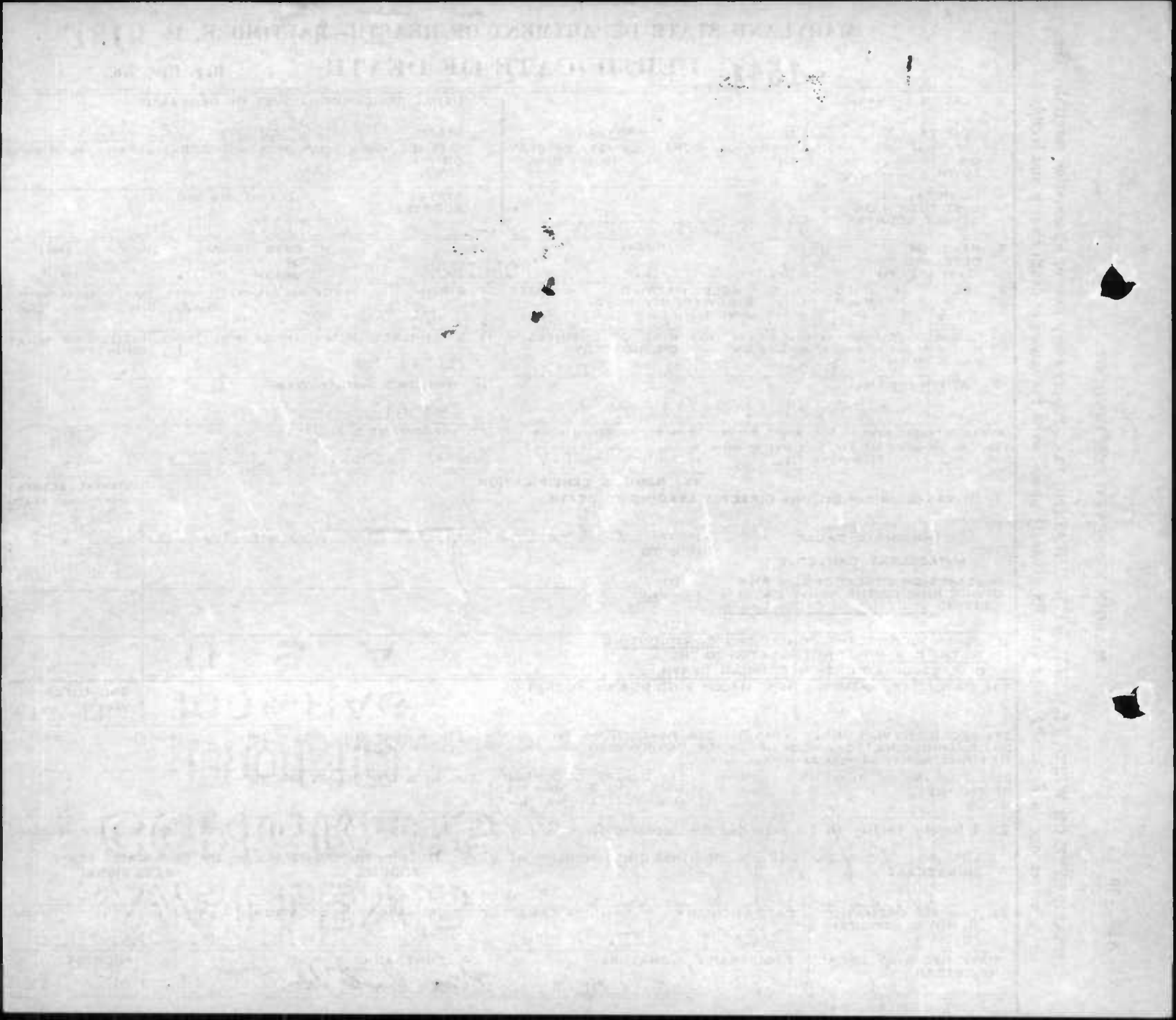
1541 CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
54 TOWN <u>Essex</u>		<u>Essex</u>	54
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
00 817 Silver Avenue		817 Silver Avenue	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print)	(First) (Middle) (Last)	OF DEATH:	
<u>EDWARD</u>	<u>A.</u>	<u>Feb. 27,</u>	<u>1956</u>
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>male</u>	<u>white</u>	<u>single</u>	<u>June 8, 1876</u>
9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>79</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
<u>Laborer</u>	<u>Roberts Can Co.</u>	<u>Maryland</u>	<u>U.S.A.</u>
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Edward A. Rollison</u>		<u>Isabella Simpson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS:	
(If Yes, give war or dates of service) --	<u>214-03-1117</u>	<u>Essex</u> <u>Mabel Vogel, 817 Silver Avenue,</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
450.0 IMMEDIATE CAUSE (A) <u>Generalized Atherosclerosis</u>			<u>Years</u>
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> M.	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2/15/56</u> 19, to <u>2/28/56</u> 19, that I last saw the deceased alive on <u>2/25/56</u> , 19, and that death occurred at <u>6A</u> M. from the causes and on the date stated above.			
SIGNATURE <u>Robert J. Lyden</u>		ADDRESS <u>M.D. 815 Eastern Ave.</u>	
DATE SIGNED <u>2/28/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>burial</u>	<u>3/1/56</u>	<u>Mt. Carmel Cemetery</u>	<u>Baltimore, Maryland</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>2/29/56</u>	<u>C. W. Hedrick</u>	<u>Wm. Bork, Inc.</u>	<u>1217 St. Paul Street</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1396

CERTIFICATE OF DEATH

Reg. Dist. No. 12

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>51</u> TOWN <u>Arbutus</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Arbutus</u> <u>51</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5510 Willys Ave.</u>				STREET ADDRESS (If rural give location) <u>5510 Willys Ave.</u>			
3. NAME OF DECEASED: (First) <u>ANNIE</u> (Middle) <u>E.</u> (Last) <u>ROLOFF</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Feb.</u> <u>12</u> <u>19 56</u>			
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Sept. 9, 1897</u>	9. AGE last birthday <u>58</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <u>Eli Caslow</u>				14. MOTHER'S MAIDEN NAME: <u>Annie C. Bortner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Arbutus</u> <u>Mr. Henry A. Roloff Sr. - 5510 Willys Ave.</u>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>260X</u> <u>Arteriosclerotic CVD</u>							
ANTECEDENT CAUSE (B) <u>Diabetes Mellitus</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Multiple Abnormalities</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/12</u> , 1953, to <u>2/12</u> , 1956 that I last saw the deceased alive on <u>2/12</u> , 1956, and that death occurred at <u>902P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John E. Steady</u>		M. D. <u>Harold M. Steady</u>		DATE SIGNED <u>2/14/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/15/56</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cem.</u>		LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-15-56</u>		REGISTRAR'S SIGNATURE <u>John E. Steady</u>		24. FUNERAL DIRECTOR <u>Wm. J. Pickner Sons - Balto</u>		ADDRESS <u>17</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

01515.

2411 N. Charles Street, Baltimore

1387

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk, Maryland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk, Maryland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3488 Dunhaven Road</u>		STREET ADDRESS (If rural, give location) <u>3488 Dunhaven Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Bronislawa</u> (Middle) <u>-</u> (Last) <u>Ruzakowski</u>	4. DATE OF DEATH (Day) <u>2</u> (Month) <u>3</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>1884</u>
9. AGE last birthday <u>72</u> yrs.		10. If under 1 year Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	11. BIRTHPLACE (State or foreign country) <u>Poland</u>
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>		13. FATHER'S NAME <u>Ignatz (L.N. Unknown)</u>	
14. MOTHER'S MAIDEN NAME <u>Catherine Wolkiewicz</u>		15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY No. <u>--</u>		17. INFORMANT AND ADDRESS <u>Frank Ruzakowski 3488 Dunhaven Rd. Dundalk, 22- Md.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

450.0
Immediate cause(a) Mercuric thrombosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Arteriosclerosis - genl.

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION
Drapetes

INTERVAL BETWEEN ONSET AND DEATH

6 days20 yrs

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10, 1955, to 2-3, 1956, that I last saw the deceasedalive on 2-2, 1956, and that death occurred at 6 PM m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

FEB 5 - 1956

William H. Chatter10010 Dundalk Ave. Balt. 24, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

16

BUREAU V. S.

FEB 8 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01516

1542 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN FORT HOWARD		9 Days		TOWN BALTIMORE (19)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS (If rural give location) 3016 SPARROWS POINT ROAD			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH			
RICHARD FILLMORE SANDERS				February 12 1956			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
MALE	WHITE	MARRIED	3-24-93	62 yrs.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
ERECTOR			STEEL COMPANY		Richmond, Virginia		U.S.A.
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Mell Sanders				Catherine Marks			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS:			
Yes WW-1				Clin. Rec., Vet. Adm. Hosp., Fort Howard, Md.			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							UNKNOWN
(A) IMMEDIATE CAUSE BRONCHOGENIC CARCINOMA RIGHT LUNG							
(B) ANTECEDENT CAUSE (S) WITH METASTASIS TO BRAIN							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							(C) DUE TO
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
2							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 3, 1956, to Feb. 12, 1956 , that I last saw the deceased March 1, 1956 , and that death occurred at 3:15 am , from the causes and on the date stated above.							
SIGNATURE D. Mark, M.D.				DATE SIGNED 2-12-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL				BALTIMORE NATIONAL CEMETERY BALTIMORE, MARYLAND			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
FEB 16 1956		Dawson L. Zartory		Walter Brooks Bradley Funeral Home		700 Willow Spring Rd., Baltimore 22, Md.	

BUREAU V. S.

FEB 17 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01517

1388 **CERTIFICATE OF DEATH**Reg. Dist. No. 41

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>DUNDALK</u>		<u>22 YRS</u>		TOWN <u>DUNDALK (22)</u>		<u>53</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>3009 DUNBRIN Rd.</u>				<u>3009 DUNBRIN Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>MELVIN</u> (Middle) <u>GEORGE</u> (Last) <u>SANDLER</u>				<u>2-16-</u> 19 <u>52</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>M.</u>	<u>W.</u>	<u>MARRIED</u>	<u>SEPT. 27, 1902</u>	<u>53</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>GRICER</u>			<u>RETAIL</u>		<u>MD.</u>		<u>U.S.A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>ANDREW E. SANDLER</u>				<u>CATHARINE HOHMAN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>				<u>MILDRED H. SANDLER - SAME</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>mild Hypertension</u>						<u>3 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Obesity</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2-10</u> , 19 <u>52</u> , to <u>2-16</u> , 19 <u>52</u> , that I last saw the deceased alive on <u>2-12</u> , 19 <u>52</u> , and that death occurred at <u>8 A.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Eugene F. Navy, M.D.</u>				ADDRESS (Street, city, town, state) <u>7001 Morningstar Rd Dundalk 22, MD.</u>			
DATE <u>2/18/56</u>				DATE SIGNED <u>not</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>2/18/56</u>		<u>DAK LAWN</u>		<u>BALTO. CO. not</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Feb 18-1956</u>		<u>William M. Kelly</u>		<u>Walter P. Kelly</u>		<u>Wendell</u>	

CERTIFICATE OF DEATH

1. DATE WHEN DEATH OCCURRED

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. OCCUPATION

7. MARITAL STATUS

8. COLOR

9. BIRTH DATE

10. BIRTH PLACE

11. BIRTH TIME

12. BIRTH WEIGHT

13. BIRTH LENGTH

14. BIRTH HEAD CIRCUMFERENCE

15. BIRTH SKIN COLOR

16. BIRTH HAIR COLOR

17. BIRTH EYE COLOR

18. BIRTH NOSE COLOR

19. BIRTH MOUTH COLOR

20. BIRTH TONGUE COLOR

21. BIRTH THROAT COLOR

22. BIRTH CHEST COLOR

23. BIRTH ABDOMEN COLOR

24. BIRTH LIMBS COLOR

25. BIRTH SKIN COLOR

26. BIRTH HAIR COLOR

27. BIRTH EYE COLOR

28. BIRTH NOSE COLOR

29. BIRTH MOUTH COLOR

30. BIRTH TONGUE COLOR

31. BIRTH THROAT COLOR

32. BIRTH CHEST COLOR

33. BIRTH ABDOMEN COLOR

34. BIRTH LIMBS COLOR

35. BIRTH SKIN COLOR

36. BIRTH HAIR COLOR

37. BIRTH EYE COLOR

38. BIRTH NOSE COLOR

39. BIRTH MOUTH COLOR

40. BIRTH TONGUE COLOR

41. BIRTH THROAT COLOR

42. BIRTH CHEST COLOR

43. BIRTH ABDOMEN COLOR

44. BIRTH LIMBS COLOR

45. BIRTH SKIN COLOR

46. BIRTH HAIR COLOR

47. BIRTH EYE COLOR

48. BIRTH NOSE COLOR

49. BIRTH MOUTH COLOR

50. BIRTH TONGUE COLOR

51. BIRTH THROAT COLOR

52. BIRTH CHEST COLOR

53. BIRTH ABDOMEN COLOR

54. BIRTH LIMBS COLOR

55. BIRTH SKIN COLOR

56. BIRTH HAIR COLOR

57. BIRTH EYE COLOR

58. BIRTH NOSE COLOR

59. BIRTH MOUTH COLOR

60. BIRTH TONGUE COLOR

61. BIRTH THROAT COLOR

62. BIRTH CHEST COLOR

63. BIRTH ABDOMEN COLOR

64. BIRTH LIMBS COLOR

65. BIRTH SKIN COLOR

66. BIRTH HAIR COLOR

67. BIRTH EYE COLOR

68. BIRTH NOSE COLOR

69. BIRTH MOUTH COLOR

70. BIRTH TONGUE COLOR

71. BIRTH THROAT COLOR

72. BIRTH CHEST COLOR

73. BIRTH ABDOMEN COLOR

74. BIRTH LIMBS COLOR

75. BIRTH SKIN COLOR

76. BIRTH HAIR COLOR

77. BIRTH EYE COLOR

78. BIRTH NOSE COLOR

79. BIRTH MOUTH COLOR

80. BIRTH TONGUE COLOR

81. BIRTH THROAT COLOR

82. BIRTH CHEST COLOR

83. BIRTH ABDOMEN COLOR

84. BIRTH LIMBS COLOR

85. BIRTH SKIN COLOR

86. BIRTH HAIR COLOR

87. BIRTH EYE COLOR

88. BIRTH NOSE COLOR

89. BIRTH MOUTH COLOR

90. BIRTH TONGUE COLOR

91. BIRTH THROAT COLOR

92. BIRTH CHEST COLOR

93. BIRTH ABDOMEN COLOR

94. BIRTH LIMBS COLOR

95. BIRTH SKIN COLOR

96. BIRTH HAIR COLOR

97. BIRTH EYE COLOR

98. BIRTH NOSE COLOR

99. BIRTH MOUTH COLOR

100. BIRTH TONGUE COLOR

101. BIRTH THROAT COLOR

102. BIRTH CHEST COLOR

103. BIRTH ABDOMEN COLOR

104. BIRTH LIMBS COLOR

105. BIRTH SKIN COLOR

106. BIRTH HAIR COLOR

107. BIRTH EYE COLOR

108. BIRTH NOSE COLOR

109. BIRTH MOUTH COLOR

110. BIRTH TONGUE COLOR

111. BIRTH THROAT COLOR

112. BIRTH CHEST COLOR

113. BIRTH ABDOMEN COLOR

114. BIRTH LIMBS COLOR

115. BIRTH SKIN COLOR

116. BIRTH HAIR COLOR

117. BIRTH EYE COLOR

118. BIRTH NOSE COLOR

119. BIRTH MOUTH COLOR

120. BIRTH TONGUE COLOR

121. BIRTH THROAT COLOR

122. BIRTH CHEST COLOR

123. BIRTH ABDOMEN COLOR

124. BIRTH LIMBS COLOR

125. BIRTH SKIN COLOR

126. BIRTH HAIR COLOR

127. BIRTH EYE COLOR

128. BIRTH NOSE COLOR

129. BIRTH MOUTH COLOR

130. BIRTH TONGUE COLOR

131. BIRTH THROAT COLOR

132. BIRTH CHEST COLOR

133. BIRTH ABDOMEN COLOR

134. BIRTH LIMBS COLOR

135. BIRTH SKIN COLOR

136. BIRTH HAIR COLOR

137. BIRTH EYE COLOR

138. BIRTH NOSE COLOR

139. BIRTH MOUTH COLOR

140. BIRTH TONGUE COLOR

141. BIRTH THROAT COLOR

142. BIRTH CHEST COLOR

143. BIRTH ABDOMEN COLOR

144. BIRTH LIMBS COLOR

145. BIRTH SKIN COLOR

146. BIRTH HAIR COLOR

147. BIRTH EYE COLOR

148. BIRTH NOSE COLOR

149. BIRTH MOUTH COLOR

150. BIRTH TONGUE COLOR

151. BIRTH THROAT COLOR

152. BIRTH CHEST COLOR

153. BIRTH ABDOMEN COLOR

154. BIRTH LIMBS COLOR

155. BIRTH SKIN COLOR

156. BIRTH HAIR COLOR

157. BIRTH EYE COLOR

158. BIRTH NOSE COLOR

159. BIRTH MOUTH COLOR

160. BIRTH TONGUE COLOR

161. BIRTH THROAT COLOR

162. BIRTH CHEST COLOR

163. BIRTH ABDOMEN COLOR

164. BIRTH LIMBS COLOR

165. BIRTH SKIN COLOR

166. BIRTH HAIR COLOR

167. BIRTH EYE COLOR

168. BIRTH NOSE COLOR

169. BIRTH MOUTH COLOR

170. BIRTH TONGUE COLOR

171. BIRTH THROAT COLOR

172. BIRTH CHEST COLOR

173. BIRTH ABDOMEN COLOR

174. BIRTH LIMBS COLOR

175. BIRTH SKIN COLOR

176. BIRTH HAIR COLOR

177. BIRTH EYE COLOR

178. BIRTH NOSE COLOR

179. BIRTH MOUTH COLOR

180. BIRTH TONGUE COLOR

181. BIRTH THROAT COLOR

182. BIRTH CHEST COLOR

183. BIRTH ABDOMEN COLOR

184. BIRTH LIMBS COLOR

185. BIRTH SKIN COLOR

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283. BIRTH ABDOMEN COLOR

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01518

1543 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Towson		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) Towson			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 606 Anneslie Road				STREET ADDRESS (If rural give location) 606 Anneslie Road			
3. NAME OF DECEASED (First) (Middle) (Last) Mrs. Josephine A. Sauerwein				4. DATE OF DEATH (Month) (Day) (Year) February 13 19 56			
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH Aug. 21, 1896		9. AGE last birthday 59 yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Mr. James Bacon				14. MOTHER'S MAIDEN NAME Lydia Gallagher			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS Mr. George P. Sauerwein, 606 Anneslie Rd.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) Myocardial Infarction						30 min.	
ANTECEDENT CAUSE(S) DUE TO (B) Atherosclerotic C.V. Dis.							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) 260x							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hepatitis + Diabetes mellitus						2 yrs.	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from August 19 54 to February 19 56, that I last saw the deceased alive on Feb 13, 19 56, and that death occurred at 11:00 A.M. from the causes and on the date stated above.							
SIGNATURE Charles G. Goff M.D.				ADDRESS (Street, city, town, state) 6201 York Rd Baltimore, Maryland			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2/16/1956		NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. REC'D BY REGISTRAR DATE FEB 15 1956		REGISTRAR'S SIGNATURE Mabel Gray		25. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, 5305 Harford Road #14			

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Usual Residence of Deceased

2. Date of Death

3. Time of Death

4. Place of Death

5. Cause of Death

6. Manner of Death

7. Name of Physician

8. Name of Coroner

9. Name of Registrar

10. Name of Informant

11. Name of Burial Place

12. Name of Burial Place

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BUREAU V. S.

FEB 16 1956

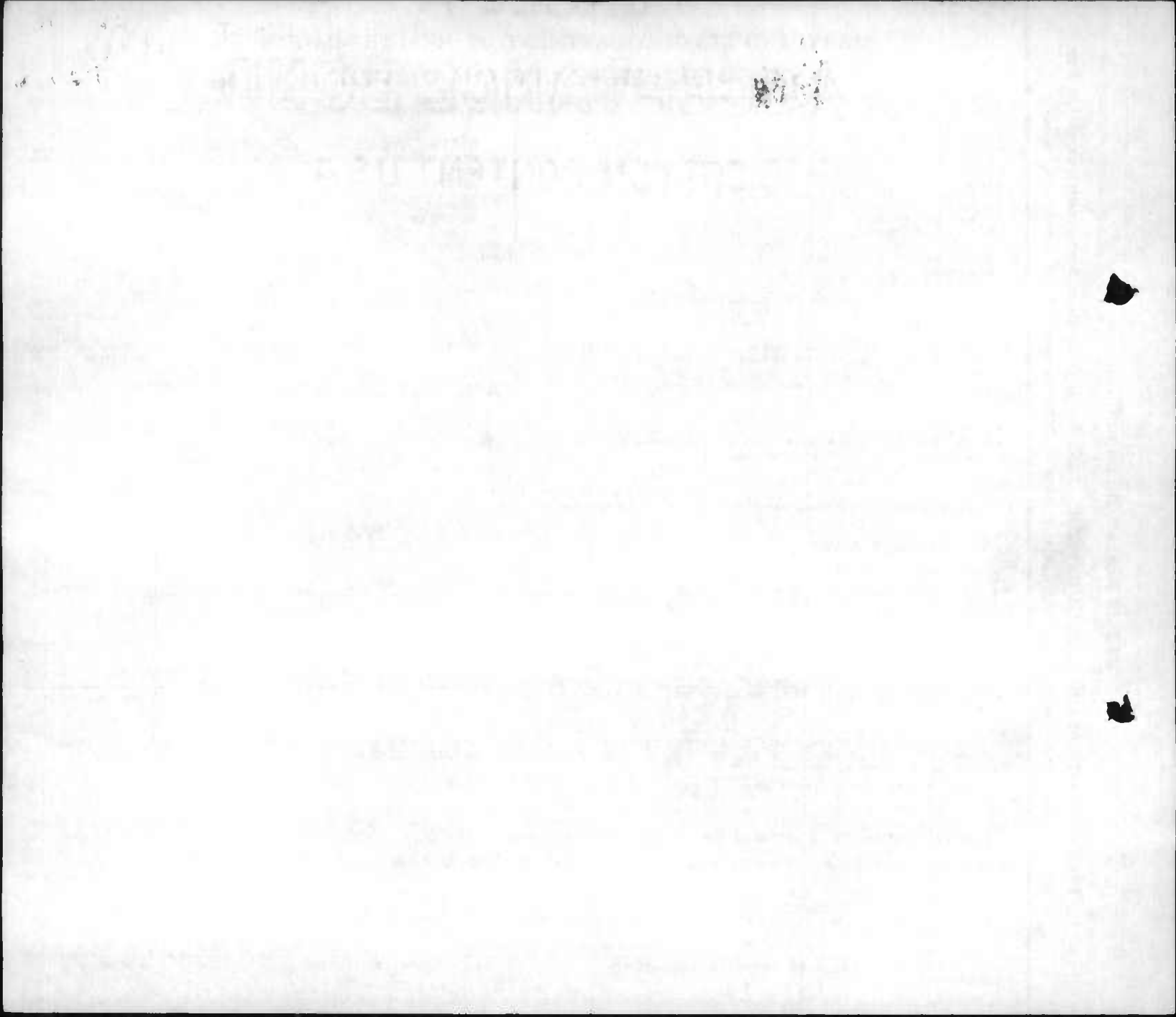
RECEIVED

1397

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>51 TOWN ARBUTHUS</u>		LENGTH OF STAY (in this place) <u>12 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ARBUTHUS</u> <u>51</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 1326 BIRCH AVE</u>				STREET ADDRESS (If rural give location) <u>1326 BIRCH AVE.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>FLORENCE V. SCHAEFER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>FEB. 22 1956</u>					
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>WIDOWED</u>	8. DATE OF BIRTH: <u>NOV. 5, 1867</u>	9. AGE last birthday: <u>88</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWORK</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>WILLIAM H. OREM.</u>				14. MOTHER'S MAIDEN NAME: <u>ANNIE MILLER.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS: <u>MRS. LOUIS HOUSTON 1326 BIRCH AVE.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						<u>1 hr</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Arteriosclerosis Generalized</u>						<u>5 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Senility</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Hypertensive Cardiovascular Disease 10 yrs.</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept</u> , 19 <u>54</u> , to <u>Feb 22, 1956</u> , that I last saw the deceased alive on <u>Dec 7, 1955</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Bradley Saighasthy MD</u>		ADDRESS <u>M.D. 1264 Francis Ave Baltimore 27 Md</u>		DATE SIGNED <u>2-23-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2/25/56</u>		NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>B. B. SPAIN</u>		REGISTRAR'S SIGNATURE <u>L</u>		24. FUNERAL DIRECTOR <u>Joseph J. Ambrose, 71328 Sulphur Sp. Rd.</u>		ADDRESS	



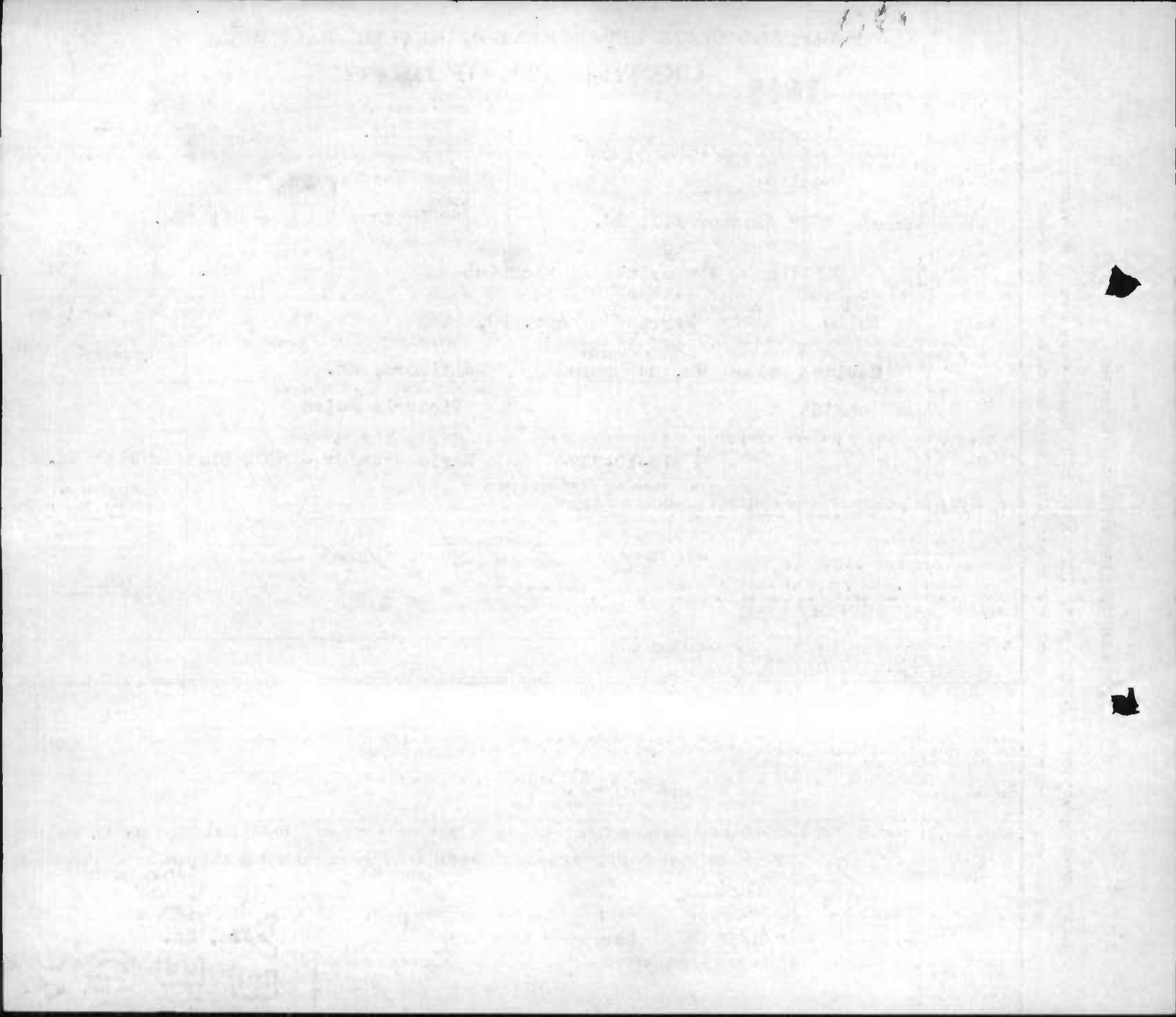
CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY		Baltimore		STATE		Md.	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		Woodlawn		COUNTY		Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		5602 Windsor Mill Rd.		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		Woodlawn	
NAME OF DECEASED:		(First) William		(Middle) Frederick		(Last) Schmidt	
SEX:		Male		DATE (Month) OF DEATH:		Feb. 5 1956	
COLOR OR RACE:		White		AGE last birthday		75 yrs.	
SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)		Married		DATE OF BIRTH:		Apr. 20, 1880	
USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Cabinet maker		BIRTHPLACE (State or foreign country):		Baltimore, Md.	
FATHER'S NAME:		John Schmidt		MOTHER'S MAIDEN NAME:		Victoria Geise	
WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		No		SOCIAL SECURITY NO.		215-10-7374	
INFORMANT & ADDRESS:		Marie Schmidt - 5602 Windsor Mill Rd.					
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A)						10 weeks	
ANTECEDENT CAUSE (S)						year	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from June, 1944, to 2-5, 1956, that I last saw the deceased alive on 2-2, 1956, and that death occurred at 9:30 AM, from the causes and on the date stated above.							
SIGNATURE		DATE SIGNED		M. D. 5907 Benjamin Franklin 2-7-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		2/8/56		Lorraine Cemetery		Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR'S ADDRESS			
Feb-8, 1956		J. W. Redick		Ellsworth Armacost - 4600 Liberty Hgts. Ave.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1545

CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonville</u> TOWN <u>30 yrs</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>612 Plymouth Road.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonville</u> OR TOWN <u>30 yrs</u> STREET ADDRESS (If rural, give location) <u>612 Plymouth Road.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>KARL - SCHMIED</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>Feb 9 19 56</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Oct. 16. 1861</u>	
9. AGE last birthday: yrs. <u>94</u>		IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, (specify if retired): <u>German Orphan Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Switzerland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Otto K. Schmied 1317 Hindermere Pk. 18</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) <u>Arteriosclerotic Heart Disease</u> DUE TO Antecedent cause(s) (b) <u>Generalized Arteriosclerosis</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)						INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>unknown</u>	
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....., 1949....., to.....Feb....., 1956....., that I last saw the deceased alive on.....Feb. 1....., 19..56, and that death occurred at.....9.30 a.....m., from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> (DEGREE OR TITLE) ADDRESS <u>1 Mallow Hill Ave., Baltimore 29, Md</u> DATE SIGNED <u>2/10/56</u>							
23. BURIAL, CREMATION REMOVAL (Specify):		DATE THEREOF <u>Feb 11-1956</u>		NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
DATE REC'D BY LOCAL REG. <u>2/10/56</u>		REGISTRAR'S SIGNATURE <u>V.E. Harvey</u>		24. FUNERAL DIRECTOR <u>John H. Seigel 5311 Edmondson Ave.</u>			

BUREAU V. S.

FEB 14 1956

RECEIVED

1

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01522

1546 CERTIFICATE OF DEATH

Items 8,9: film G193 3-5-56L

Reg. Dist. No. 30

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Ma.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6314 Frederick Ave.</u>				STREET ADDRESS (If rural give location) <u>6314 Frederick Ave.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Rust</u> <u>--</u> <u>Scott</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 14</u> <u>19</u> <u>56</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1893</u> <u>April 24, 1911</u>	9. AGE last birthday <u>62</u> <u>97</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Picket Mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dulaney-Vernay</u>		11. BIRTHPLACE (State or foreign country) <u>Vermont</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Lucius B. Scott</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Furrill</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Mrs. Ella Scott 6314 Fred. Ave.</u>			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
433.1 IMMEDIATE CAUSE (A) <u>Myocardial Decomensation</u>						2 mo.	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Quinidian Fibrillation</u>						6 yr.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-20</u> , 19 <u>44</u> , to <u>2-14</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-13</u> , 19 <u>56</u> , and that death occurred at <u>5:00</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Walter K. Gallagher</u>				ADDRESS (Street, city, town, state) <u>M. D. 6209 Frederick Rd. Baltimore 428 Md.</u> DATE SIGNED <u>2/14/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>removal</u>		DATE THEREOF <u>2-14-56</u>		NAME OF CEMETERY OR CREMATORY <u>Maury Cemetery</u>		LOCATION (City, town, or county) (State) <u>Richmond Virginia</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>T. E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS <u>Foley Funeral Home, Catonsville, Md</u>	
DATE <u>Feb. 16, 1956</u>							

STATE CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

Reg. Dist. No.

1. DECEASED PERSON'S NAME IN FULL

2. PLACE OF DEATH

3. SEX

4. DATE

5. TIME

6. CAUSE

7. PLACE OF BIRTH

8. OCCUPATION

9. MARITAL STATUS

10. PREVIOUS MARRIAGES

11. PREVIOUS DEATHS

12. PREVIOUS ILLNESS

13. PREVIOUS SURGERY

14. PREVIOUS TRAUMA

15. PREVIOUS DRUGS

16. MEDICAL CERTIFICATION

17. SIGNATURE OF PHYSICIAN

18. SIGNATURE OF REGISTRAR

19. SIGNATURE OF WITNESSES

20. SIGNATURE OF DECEASED

21. SIGNATURE OF FUNERAL HOME

22. SIGNATURE OF BURIAL PLACE

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF CORONER

25. SIGNATURE OF JURY

26. SIGNATURE OF JUDGE

27. SIGNATURE OF CLERK

28. SIGNATURE OF RECORDER

29. SIGNATURE OF ARCHIVER

30. SIGNATURE OF INDEXER

31. SIGNATURE OF QUALIFIER

32. SIGNATURE OF REGISTRAR

33. SIGNATURE OF WITNESSES

34. SIGNATURE OF DECEASED

35. SIGNATURE OF FUNERAL HOME

36. SIGNATURE OF BURIAL PLACE

37. SIGNATURE OF INTERVIEWER

38. SIGNATURE OF CORONER

39. SIGNATURE OF JURY

40. SIGNATURE OF JUDGE

BUREAU V. S.

FEB 16 1956

RECEIVED

RECEIVED

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01523

Items 8 & 9: Film G194

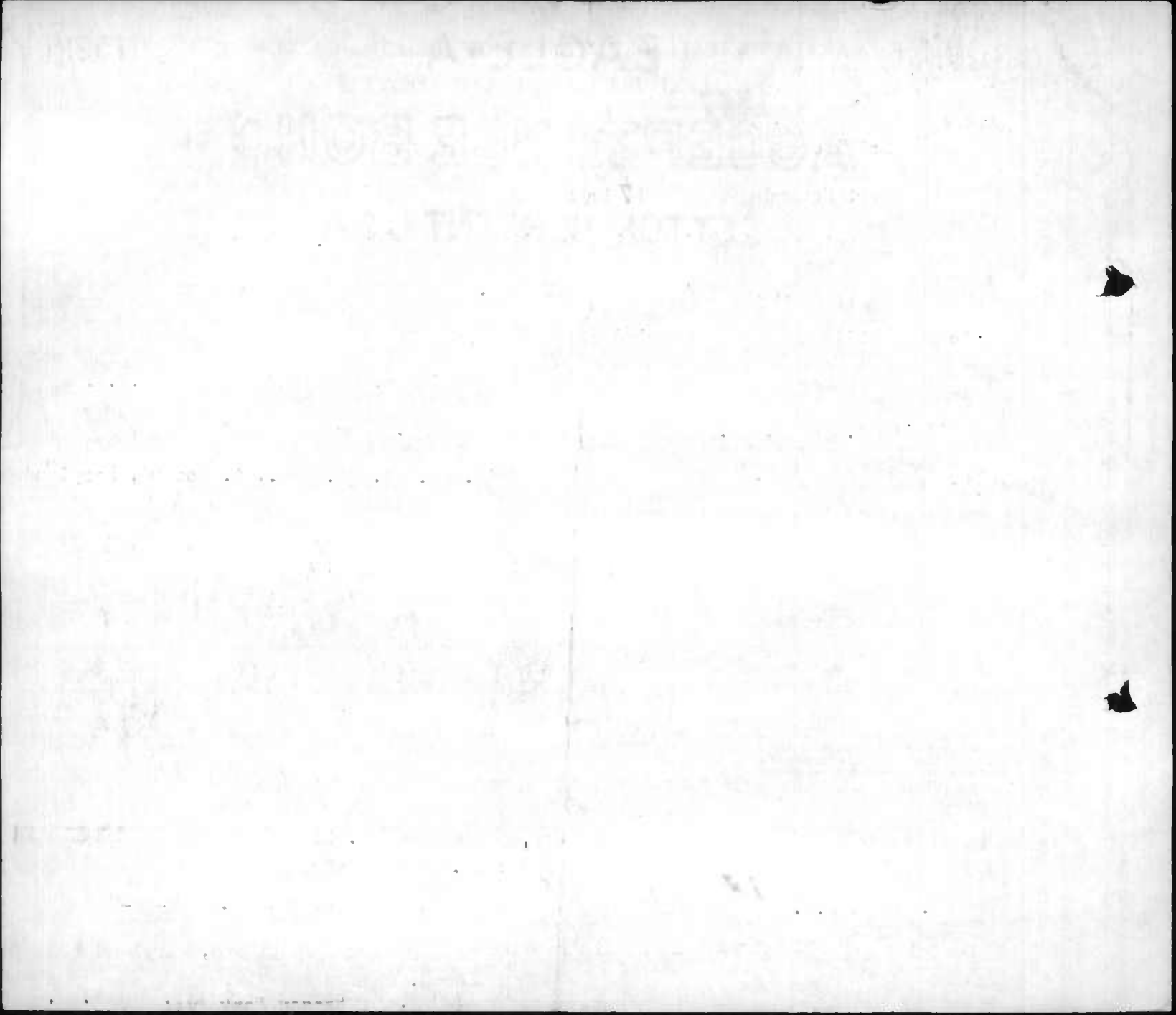
3/14/56 dmr.

1547

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>18</u> Days		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>2640 E. Oliver Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>WILLIAM A SCOTT JR.</u>				<u>February 21 1956</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>12/16/98 97</u>	
9. AGE last birthday: <u>58</u> yrs.		10. IF UNDER 1 YEAR: Months Days		11. IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Plumber</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>William A. Scott, Sr.</u>				14. MOTHER'S MAIDEN NAME: <u>Susan R. Bears</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW-I</u>				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Maryland</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>BRONCHOGENIC CARCINOMA LEFT UPPER LOBE</u>						UNKNOWN	
ANTECEDENT CAUSE (B) <u>WITH METASTASIS TO KIDNEYS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>LOBULAR PNEUMONIA</u>						UNKNOWN	
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 5, 1956</u> , to <u>Feb. 21, 1956</u> , that I last saw the deceased <u>alive on 12/16/98 97</u> and that death occurred at <u>9:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>D. MARK, M.D.</u>		ADDRESS <u>VAH, Fort Howard, Md.</u>		DATE SIGNED <u>2-22-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF <u>2-27-56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE/REC'D BY LOCAL REGISTRAR <u>2-23-1952</u>		REGISTRAR'S SIGNATURE <u>W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Leo G. Cook</u>		ADDRESS <u>1703 N. Paterson Park Ave. Balto. Md.</u>	



01524

MARYLAND STATE DEPARTMENT OF HEALTH

1548

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (In this place) <u>10 yr 2 mos 12 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				STREET ADDRESS <u>Helping Up Mission Lombard & Green Sts.</u>	
3. NAME OF DECEASED (Type or Print) <u>Fred</u>		(First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year) <u>February 3, 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>2-11-1880</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		9. AGE last birthday <u>75</u> yrs.	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Seiling</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Whipple</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY No. <u>Unknown</u>		17. INFORMANT AND ADDRESS <u>Records Spring Grove State Hospital</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Lobar pneumonia</u>		<u>5 days</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Carcinoma of stomach</u>		
---	--	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

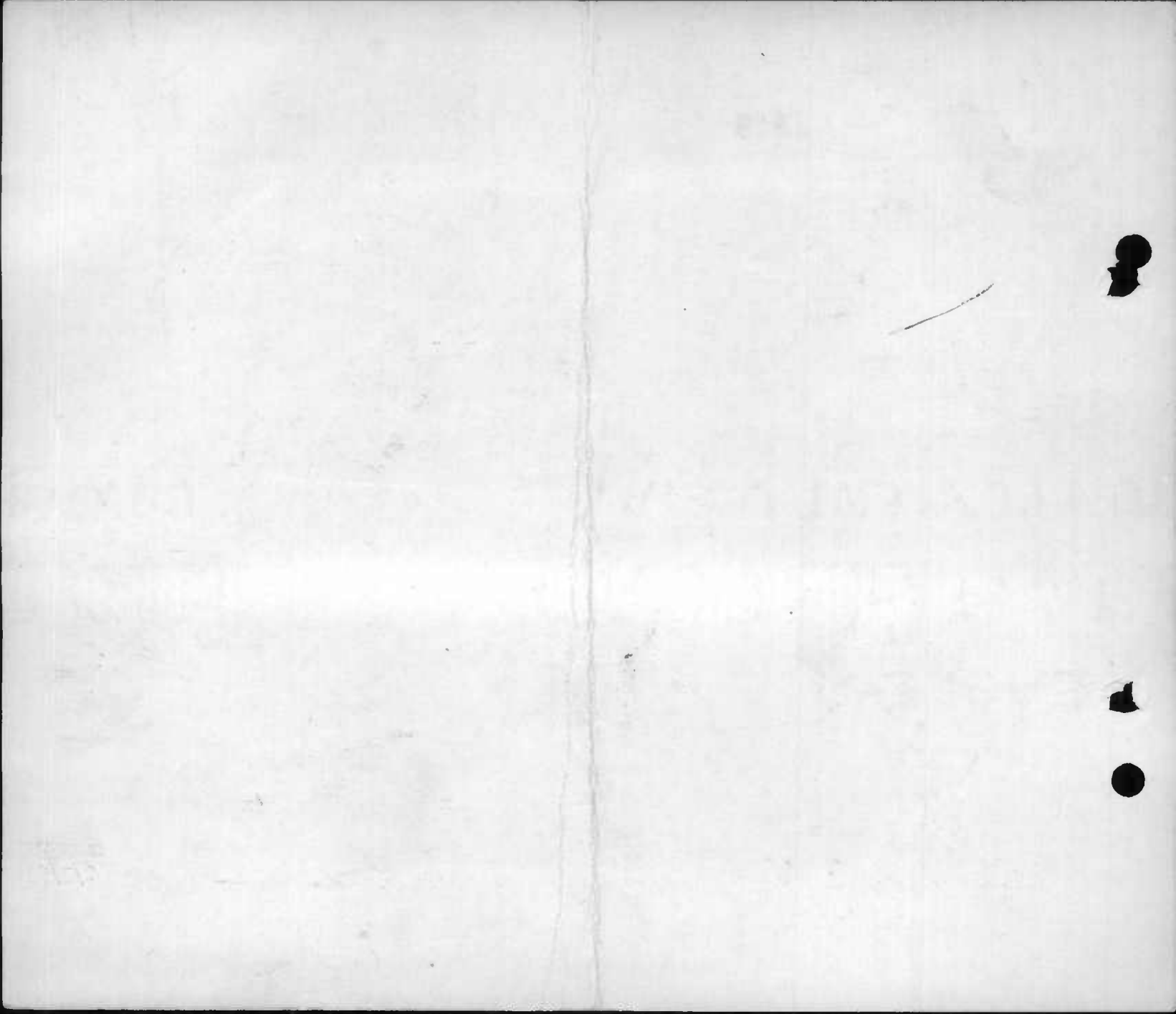
ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>4-6-1956</u>	<u>Edin Ballou</u>	<u>1010 Leeds Ave</u>	<u>md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>Feb 6, 1956</u>	<u>J. E. Hedrick</u>	<u>Wm Cook Inc</u>	<u>1217 St Paul St</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1549

CERTIFICATE OF DEATH

Item 7, Film G193 2-27-56 et

Reg. Dist. No. 43

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Raspensburg</u>		<u>104 yrs</u>		TOWN <u>Raspensburg</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>7418 Brightside Ave</u>				<u>7418 Brightside Ave</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <u>IDA</u>		(Middle) <u>Celestial</u>		(Last) <u>SHENK</u>		(Month) (Day) (Year)	
(Type or Print)						<u>Feb 18 1956</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>Female</u>		<u>White</u>		<u>Widowed</u>		<u>Aug 7-1871</u>	
9. AGE last birthday:		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<u>84</u> yrs.		Months		Days		Hours	
						Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>athome</u>				<u>housewife</u>		<u>Va</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Benjamin Hanson</u>				<u>Catherine Walton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:			
<u>No</u>							
17. INFORMANT & ADDRESS:							
<u>Mrs. Bertha Wolf</u>				<u>7418 Brightside Ave.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause						<u>6 hrs</u>	
(a) <u>Cerebrovascular accident</u>							
DUE TO							
Antecedent causes (s)						<u>2 yrs</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.							
(b) <u>Arteriosclerotic Cardio-vascular disease</u>							
DUE TO							
(c)							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
20. AUTOPSY ?				Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?			
22. I hereby certify that I attended the deceased from <u>Jan 1, 1956</u> to <u>Feb 18, 1956</u> , that I last saw the deceased alive on <u>Feb 18, 1956</u> , and that death occurred at <u>1:53 PM</u> , from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Wm Baumgardner MD</u>				<u>2/19/56</u>			
23. BURIAL, CREMATION, REMOVAL, (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/22/56</u>		<u>Beckons Chapel</u>		<u>Luray Va</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Feb 19-1956</u>		<u>Dr. W. D. Raybinder</u>		<u>Lassalle Funeral Home</u>		<u>4491 Behav Rd.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
FEB 23 1956
BUREAU Y. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01526

1550 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Lutherville</u>				TOWN <u>Lutherville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bellona Avenue</u>				STREET ADDRESS (If rural give location) <u>Bellona Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>JOHN</u> (Middle) <u>BARCLAY</u> (Last) <u>SHOCK</u>				Feb. 24, 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Married	May 26, 1894	61	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Shipping Clerk</u>		<u>Crown Cork & Seal</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>George Shock</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Parks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
Yes <input checked="" type="checkbox"/> WW I				<u>Family Records</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Heart Disease,</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7405.</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/28</u> , 19 <u>55</u> , to <u>2/24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>11/28</u> , 19 <u>55</u> , and that death occurred at <u>10</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Bennett A. Hecox M.D. Consultant M.E. Lutherville</u>				DATE SIGNED <u>2/22/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 28, 1956</u>		<u>Prospect Hill Cemetery</u>		<u>Towson, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>EB 29 1956</u>		<u>Anne H. McRay</u>		<u>John Burns' Sons,</u>		<u>Towson, Maryland</u>	

01584

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Race (Print or write race)

4. Date of birth (Print or write date)

5. Place of birth (Print or write place)

6. Usual residence (Print or write address)

7. Date of death (Print or write date)

8. Time of death (Print or write time)

9. Cause of death (Print or write cause)

10. Signature of physician (Print or write name)

11. Signature of registrar (Print or write name)

12. Signature of medical examiner (Print or write name)

13. Signature of coroner (Print or write name)

14. Signature of funeral director (Print or write name)

15. Signature of undertaker (Print or write name)

16. Signature of cemetery (Print or write name)

17. Signature of hospital (Print or write name)

18. Signature of nursing home (Print or write name)

19. Signature of other institution (Print or write name)

20. Signature of other institution (Print or write name)

21. Signature of other institution (Print or write name)

22. Signature of other institution (Print or write name)

23. Signature of other institution (Print or write name)

24. Signature of other institution (Print or write name)

25. Signature of other institution (Print or write name)

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62. Signature of other institution (Print or write name)

63. Signature of other institution (Print or write name)

64. Signature of other institution (Print or write name)

65. Signature of other institution (Print or write name)

66. Signature of other institution (Print or write name)

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82. Signature of other institution (Print or write name)

83. Signature of other institution (Print or write name)

84. Signature of other institution (Print or write name)

85. Signature of other institution (Print or write name)

BUREAU V. S.

FEB 29 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

1551

CERTIFICATE OF DEATH

01527

Reg. Dist. No. 30

Item 2, Film G193 2-28-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		STATE <u>MD.</u>		COUNTY <u>BALTO</u>			
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>5014 BALTIMORE</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE 25</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>10 PARADISE HOME</u>				STREET ADDRESS <u>114 Maude Avenue</u> (If rural give location) <u>ANN.</u>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MARGARET SKINNER</u>				<u>2-16-56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>3/25/82</u>	9. AGE last birthday <u>73</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Columbus Oliver</u>				14. MOTHER'S MAIDEN NAME <u>MINNIE JOSEPHINE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Family - Same</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Hypertensive cardio vascular disease,</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10/4/52</u>	
ANTECEDENT CAUSE(S) DUE TO <u>endarteritis obliterans right leg.</u>						<u>3/53</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Diabetes Mellitus</u>						<u>?</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/4/52</u> , 19 <u>Feb 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb. 14</u> , 19 <u>56</u> , and that death occurred at <u>1226 Hanover Street</u> , M, from the causes and on the date stated above.							
SIGNATURE <u>Harry Deplee</u> M.D.				DATE SIGNED <u>2/17/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>B.</u>		DATE THEREOF <u>2/20/56</u>		NAME OF CEMETERY OR CREMATORY <u>CAR LAWN</u>		LOCATION (City, town, or county) (State) <u>BALTO</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>T. E. Barry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ed. Cleary Funeral Home</u>		ADDRESS	
DATE <u>FEB 20 1956</u>							

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

2 **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01528

1552

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2403 Old Frederick Rd</u>				STREET ADDRESS (If rural give location) <u>2403 Old Frederick Rd</u>			
3. NAME OF DECEASED (Type or Print) <u>Edward W. Smith</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb. 17/56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 10, 1900</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Messenger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Brinks, Inc.</u>		11. BIRTHPLACE (State or foreign country) <u>Wisconsin</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>-----Smith</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>yes no war</u>		16. SOCIAL SECURITY NO. <u>579 20 2192</u>		17. INFORMANT & ADDRESS <u>Mrs. Florence F. Smith, 2403 Old Frederick Rd. Cat. 28</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
177X IMMEDIATE CAUSE (A) <u>Carcinoma (metastatic) liver</u>		ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma; prostate</u>		INTERVAL BETWEEN ONSET AND DEATH		<u>2 weeks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE		STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Carcinoma; prostate</u>				<u>2 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>8:55</u> , 19 <u>55</u> , to <u>2:47</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2-21</u> , 19 <u>56</u> , and that death occurred at <u>3 P.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Stephen Lee Magness</u> M.D.				ADDRESS (Street, city, town, state) <u>908 Frederick Rd. Catonsville, Md.</u>			
DATE THEREOF <u>Feb. 21/56</u>				DATE SIGNED <u>2-20-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Balto. 29, Md.</u>			
24. REC'D BY REGISTRAR <u>FEB 21 1956</u>		REGISTRAR'S SIGNATURE <u>V. E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witzke</u>		ADDRESS <u>Edmondson Ave</u>	

CERTIFICATE OF DEATH

Form No. 1

ATTEST: REGISTERED DEATHS OF MASSACHUSETTS

NAME OF DECEASED: John Doe

AGE: 45 YEARS

SEX: Male

DATE OF BIRTH: Jan 15, 1880

DATE OF DEATH: Feb 21, 1925

PLACE OF DEATH: Home

CAUSE OF DEATH: Heart Disease

IMMEDIATE CAUSE: Myocardial Infarction

INTERMEDIATE CAUSE: Coronary Atherosclerosis

UNDERLYING CAUSE: Arteriosclerosis

PREVIOUS ILLNESS: None

PREVIOUS SURGERY: None

PREVIOUS TRAUMA: None

PREVIOUS DRUGS: None

PREVIOUS ACCIDENTS: None

PREVIOUS INFECTIONS: None

PREVIOUS TUBERCULOSIS: None

PREVIOUS SYPHILIS: None

PREVIOUS GONORRHOEA: None

PREVIOUS CHLAMYDIA: None

PREVIOUS TRICHOMONAS: None

PREVIOUS CANDIDA: None

PREVIOUS CRYPTOCOCCUS: None

PREVIOUS HISTOPLASMA: None

PREVIOUS COCCIDIUM: None

PREVIOUS TOXOPLASMA: None

PREVIOUS CYTOSPORIDIUM: None

PREVIOUS MICROSPORIDIUM: None

NAME OF PHYSICIAN: Dr. J. H. Smith

NAME OF SURGEON: None

NAME OF PATHOLOGIST: Dr. A. B. Jones

NAME OF ANATOMIST: None

NAME OF ENTOMOLOGIST: None

NAME OF MICROBIOLOGIST: None

NAME OF CHEMIST: None

NAME OF PHYSICIAN: Dr. J. H. Smith

NAME OF SURGEON: None

NAME OF PATHOLOGIST: Dr. A. B. Jones

NAME OF ANATOMIST: None

NAME OF ENTOMOLOGIST: None

NAME OF MICROBIOLOGIST: None

NAME OF CHEMIST: None

NAME OF PHYSICIAN: Dr. J. H. Smith

NAME OF SURGEON: None

NAME OF PATHOLOGIST: Dr. A. B. Jones

NAME OF ANATOMIST: None

NAME OF ENTOMOLOGIST: None

NAME OF MICROBIOLOGIST: None

NAME OF CHEMIST: None

NAME OF PHYSICIAN: Dr. J. H. Smith

NAME OF SURGEON: None

NAME OF PATHOLOGIST: Dr. A. B. Jones

NAME OF ANATOMIST: None

NAME OF ENTOMOLOGIST: None

NAME OF MICROBIOLOGIST: None

NAME OF CHEMIST: None

NAME OF PHYSICIAN: Dr. J. H. Smith

RECEIVED
FEB 21 1925
BUREAU V. S.

1

INSTRUCTIONS

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VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01529

1553 CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		LENGTH OF STAY (in this place) <u>3 year</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Masonic Home of Md</u>				STREET ADDRESS (If rural give location) <u>3402 St. Ambrose Ave.</u>			
3. NAME OF DECEASED (Type or Print) <u>Sallie Sommerwerck</u>				4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>23</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>		8. DATE OF BIRTH <u>July 26, 1878</u>	
9. AGE last birthday <u>77</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Alfred Clatchey</u>		14. MOTHER'S MAIDEN NAME <u>Laura O. Staunberry</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or date of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Elmer Dimmis - Masonic Home</u>		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
18a. IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardio-Vascular Disease</u>				18b. ANTECEDENT CAUSE(S) DUE TO			
18c. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) <u>UNDERLYING CAUSE LAST.</u>				18d. DUE TO (C)			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of injury street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 23, 1953</u> , to <u>Feb 23, 1956</u> , that I last saw the deceased alive on <u>Feb 22, 1956</u> , and that death occurred at <u>3:22</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Walter T. Kus</u>				ADDRESS (Street, city, town, state) <u>Cockeysville, Md</u>		DATE SIGNED <u>2/23/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 25, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
24. REC'D BY REGISTRAR <u>FEB 27 1956</u>		REGISTRAR'S SIGNATURE <u>Anne MacKee</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Wok Inc</u>		ADDRESS <u>1217 St Paul St</u>	

1

INSTRUCTIONS

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16-A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01550

1554

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Woodlawn</u>		<u>30 yrs</u>		TOWN <u>Woodlawn</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2001 Windsor Place</u>				STREET ADDRESS (If rural give location) <u>2001 Windsor Place</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Annie</u> (Middle) <u>K.</u> (Last) <u>Souder</u>				(Month) <u>Feb.</u> (Day) <u>24</u> (Year) <u>19 56</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Oct. 14, 1874</u>	9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Kelly Clinic</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-10-6216</u>		17. INFORMANT & ADDRESS <u>Mr. I. N. Smith, 602 N. Franklinton Rd</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC Cardiovascular Disease</u>							
ANTECEDENT CAUSE(S) DUE TO <u>Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JAN</u> , 19 <u>53</u> , to <u>2/24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/23</u> , 19 <u>56</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Thos E. Roach</u>				ADDRESS (Street, city, town, state) <u>3629 Edmondson Ave</u>		DATE SIGNED <u>2/25/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 27/56</u>		NAME OF CEMETERY OR CREMATORY <u>Louison Park</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR <u>EB 27 1956</u>		REGISTRAR'S SIGNATURE <u>Dr. Thos Martin</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Wolfe</u>		ADDRESS <u>4101 Edmondson Ave</u>	

CERTIFICATE OF DEATH

1925

FILE NO.

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF REGISTRAR

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF WITNESSES

13. PLACE OF INTERMENT

14. TIME OF INTERMENT

15. SIGNATURE OF INTERMENT AGENT

16. SIGNATURE OF CLERK

17. SIGNATURE OF ASSISTANT CLERK

18. PLACE OF BIRTH

19. AGE

20. OCCUPATION

21. CAUSE OF DEATH

22. DATE OF DEATH

23. PLACE OF DEATH

24. TIME OF DEATH

25. SIGNATURE OF REGISTRAR

26. SIGNATURE OF PHYSICIAN

27. SIGNATURE OF WITNESSES

28. PLACE OF INTERMENT

29. TIME OF INTERMENT

30. SIGNATURE OF INTERMENT AGENT

31. SIGNATURE OF CLERK

32. SIGNATURE OF ASSISTANT CLERK

33. PLACE OF BIRTH

34. AGE

35. OCCUPATION

36. CAUSE OF DEATH

37. DATE OF DEATH

38. PLACE OF DEATH

39. TIME OF DEATH

40. SIGNATURE OF REGISTRAR

41. SIGNATURE OF PHYSICIAN

42. SIGNATURE OF WITNESSES

43. PLACE OF INTERMENT

44. TIME OF INTERMENT

45. SIGNATURE OF INTERMENT AGENT

46. SIGNATURE OF CLERK

47. SIGNATURE OF ASSISTANT CLERK

48. PLACE OF BIRTH

49. AGE

50. OCCUPATION

51. CAUSE OF DEATH

52. DATE OF DEATH

53. PLACE OF DEATH

54. TIME OF DEATH

55. SIGNATURE OF REGISTRAR

56. SIGNATURE OF PHYSICIAN

57. SIGNATURE OF WITNESSES

58. PLACE OF INTERMENT

59. TIME OF INTERMENT

60. SIGNATURE OF INTERMENT AGENT

61. SIGNATURE OF CLERK

62. SIGNATURE OF ASSISTANT CLERK

63. PLACE OF BIRTH

64. AGE

65. OCCUPATION

66. CAUSE OF DEATH

67. DATE OF DEATH

68. PLACE OF DEATH

69. TIME OF DEATH

70. SIGNATURE OF REGISTRAR

71. SIGNATURE OF PHYSICIAN

72. SIGNATURE OF WITNESSES

73. PLACE OF INTERMENT

74. TIME OF INTERMENT

75. SIGNATURE OF INTERMENT AGENT

76. SIGNATURE OF CLERK

77. SIGNATURE OF ASSISTANT CLERK

78. PLACE OF BIRTH

79. AGE

80. OCCUPATION

81. CAUSE OF DEATH

82. DATE OF DEATH

83. PLACE OF DEATH

84. TIME OF DEATH

85. SIGNATURE OF REGISTRAR

86. SIGNATURE OF PHYSICIAN

87. SIGNATURE OF WITNESSES

88. PLACE OF INTERMENT

89. TIME OF INTERMENT

90. SIGNATURE OF INTERMENT AGENT

91. SIGNATURE OF CLERK

92. SIGNATURE OF ASSISTANT CLERK

BUREAU V. S.

FEB 29 1925

RECEIVED

1398 CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD.</u>		COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
51 TOWN <u>ARBUTUS</u>		34 yrs.		51 TOWN <u>ARBUTUS</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 <u>1244 STEUENS AVE.</u>				1 <u>1244 STEUENS AVE</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>FLORENCE SPIEKER</u>				2 - 6 1956			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
FEMALE		WHITE		WIDOWED		9-2-1978	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months Days Hours Min.	
77 yrs.							
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
HOUSE WORK				AT HOME		BALTO. MD.	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME:			
U.S.A.				WILLIAM HOFFMAN			
14. MOTHER'S MAIDEN NAME:				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)			
ELIZABETH				NO			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS:			
				HUSBAND EDWARD H. SPIEKER (SAME)			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) Chronic hypertension - 2 arterial sclerosis							
ANTECEDENT CAUSE (B) Myocarditis - 2 decompensation							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
0							
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)			
				21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from , 1930, to Feb 6th 1956, that I last saw the deceased alive on Feb 5, 1956, and that death occurred at M, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
D. Frederic V. Becker				M.D. 1014 Francis Ave Balto 7 2-7-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY			
BURIAL				LODON PK			
DATE REC'D BY LOCAL REGISTRAR				LOCATION (City, town, or county) (State)			
2/8/56				BALTO. MD.			
REGISTRAR'S SIGNATURE				24. FUNERAL DIRECTOR			
J. Walter Conklin				ADDRESS			
5444 BELAIR RD							

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12101

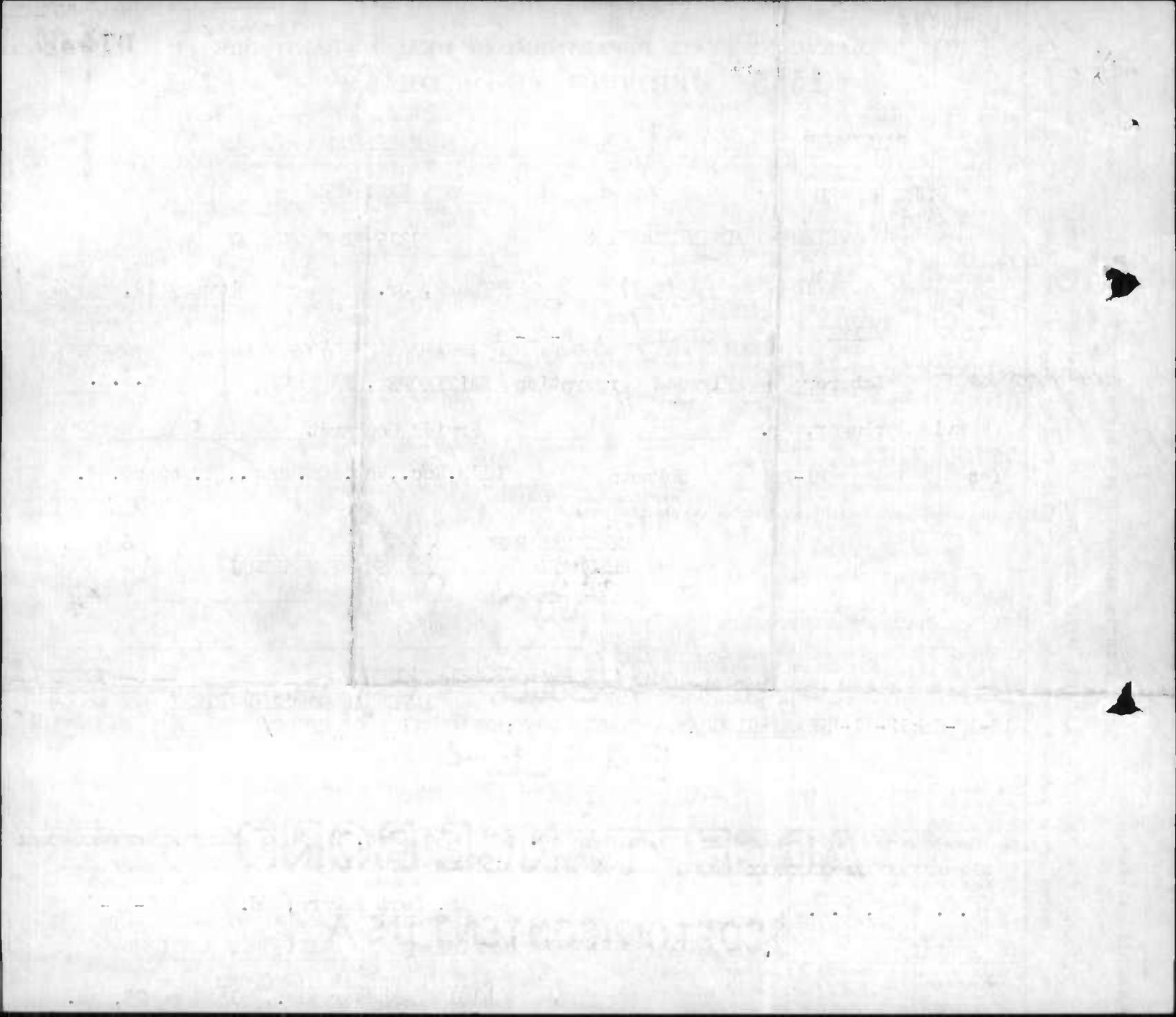
1555 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
X TOWN <u>FORT HOWARD</u>		<u>6 days</u>		TOWN <u>BALTIMORE</u>		<u>3701-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION</u>				STREET ADDRESS (If rural give location) <u>3315 EDMONDSON AVENUE</u>			
3. NAME OF DECEASED: (First) <u>DAVID</u>		(Middle) <u>(NMI)</u>		(Last) <u>SPRINGER, Jr.</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>February 12, 1956</u>	
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH: <u>8-26-26</u>	9. AGE last birthday <u>29</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Plywood Corporation</u>		11. BIRTHPLACE (State or foreign country): <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>David Springer, Sr.</u>				14. MOTHER'S MAIDEN NAME: <u>Freida Gephardt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>P1-28</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CEREBRAL EMBOLISM</u>						<u>6 DAYS</u>	
DUE TO ANTECEDENT CAUSE (S) <u>RHEUMATIC HEART DISEASE WITH MITRAL STENOSIS</u>						<u>UNKNOWN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CEREBRAL VESSEL ANEURYSM</u>						<u>CONGENITAL</u>	
19A. DATE OF OPERATION: <u>12-10-55; 12-11-55</u>		19B. MAJOR FINDINGS OF OPERATION <u>INTERNAL CAROTID ARTERY ARTERIOGRAM & TRACHEOTOMY; EXPLORATION OF RIGHT</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 6</u> , 19 <u>56</u> to <u>Feb. 12</u> , 19 <u>56</u> , that I saw the deceased <u>alive on</u> <u>Feb. 12, 1956</u> , and that death occurred at <u>3:55 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>C. B. COPE, M.D.</u>		ADDRESS <u>M. D. VAH, Fort Howard, Md.</u>		DATE SIGNED <u>2-12-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>Feb. 15/56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-15-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>WITZKE FUNERAL DIRECTORS</u>		ADDRESS <u>1101 Edmondson Ave., Baltimore 29, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1556 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Balto.	MARYLAND	STATE Md.	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS House in the Pines		STREET ADDRESS (If rural give location) 2733 St. Paul St.	
3. NAME OF DECEASED: (First) JOHN (Middle) R. M. (Last) STAUM		4. DATE (Month) (Day) (Year) OF DEATH: Feb. 16, 19 56	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed	8. DATE OF BIRTH: Mar. 1, 1873
9. AGE last birthday 82 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: John Wesley Staum		14. MOTHER'S MAIDEN NAME: Juliet Armager	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT & ADDRESS: Mr. John W. Staum - 3818 Greenmount Ave.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) Broncho-Pneumonia		5 da	
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Ch. Hypertensive Cardio-Vascular Disease			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 8-26 , 19 55 , to 2-16 , 19 56 , that I last saw the deceased alive on 2-16 , 19 56 , and that death occurred at 10:50 A.M. , from the causes and on the date stated above.			
SIGNATURE William K. Gallagher		ADDRESS M. D. Catonsville 4-28, Md.	
DATE SIGNED 2-17-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 2/18/56	
NAME OF CEMETERY OR CREMATORY Mt. Olivet Cem.		LOCATION (City, town, or county) (State) Balto., Md.	
DATE REC'D BY LOCAL REGISTRAR February 18-1956		REGISTRAR'S SIGNATURE R.W.	
24. FUNERAL DIRECTOR Wm. J. Lickner & Sons - Balto.		ADDRESS 17 Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECORDS OF DEPARTMENT OF DEFENSE

NAME		RANK		COMPONENT		DATE	

1557 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MD.	COUNTY BALTO.
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 CATONSVILLE	LENGTH OF STAY (in this place) 2 YEARS, 11 MONTHS	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Daniels	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 SPRING GROVE STATE HOSP.		STREET ADDRESS (If rural give location) DANIELS, MD	
3. NAME OF DECEASED: (First) (Middle) (Last) ALICE C STEWART		4. DATE (Month) (Day) (Year) OF DEATH: 3 22 1956	
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: ? UNKNOWN
9. AGE last birthday 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): W. VIRGINIA
13. FATHER'S NAME: J. H. WALKER		14. MOTHER'S MAIDEN NAME: ANNIE ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.: UNKNOWN	
17. INFORMANT & ADDRESS: MRS. RICHARD LANDACRE			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) CARDIAC FAILURE			2/19/56
ANTECEDENT CAUSE (S) (B) HYPERTENSIVE CARDIO-VASCULAR DISEASE			2/22/56
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. 260X (C) ARTERIOSCLEROSIS			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. DIABETES - CONVULSIVE DISORDER			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3/3 , 19 54 , to 2/22 , 19 56 , that I last saw the deceased alive on 2/22 , 19 56 , and that death occurred at 12²⁰ A.M. from the causes and on the date stated above.			
SIGNATURE Stella Wachler		ADDRESS Spring Grove St. Hospital DATE SIGNED 2/24/56	
23. BURIAL - CREMATION, REMOVAL, (Specify)		NAME OF CEMETERY OR CREMATORY	
DATE THEREOF 2/24/56		LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR 2/24/56		24. FUNERAL DIRECTOR ADDRESS	
REGISTRAR'S SIGNATURE J. E. Harvey			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

173

174

1857

MD

INFORMATION

150cm

CM 150cm

SC SS S

THIRTY

5

THIRTY

80

THIRTY

W

7

2.0

W. THIRTY

THIRTY

THIRTY

THIRTY

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THIRTY

THIRTY

THIRTY

THIRTY

BUREAU V. 3

FEB 28 1956

RECEIVED

Item 8 FilmG193 2-24-56 et

1558

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Towson</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8 Burke Avenue</u>				STREET ADDRESS (If rural give location) <u>8 Burke Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>CHARLES EDGAR STOVER</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>February 13, 19 56</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>1870</u> <u>Sept. 20, 1871</u>	9. AGE last birthday <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Supervisor-retired</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Steel mfg. co.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Isaac Stover</u>				14. MOTHER'S MAIDEN NAME: <u>Eleanor Vance</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Richard Stover, Towson, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						<u>1 hour</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Coronary Sclerosis</u>						<u>5 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1940</u> , 19....., to <u>2-13</u> , 1956 that I last saw the deceased alive on <u>1-31</u> , 1956, and that death occurred at <u>6 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>C. W. Peake</u>				ADDRESS <u>M. D. 4508 Harford Rd</u>		DATE SIGNED <u>2-15-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 15, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		LOCATION (City, town, or county) (State) <u>Parkville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb. 15, 1956</u>		REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>		FUNERAL DIRECTOR <u>John Burns Sons</u>		ADDRESS <u>Towson, Maryland</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

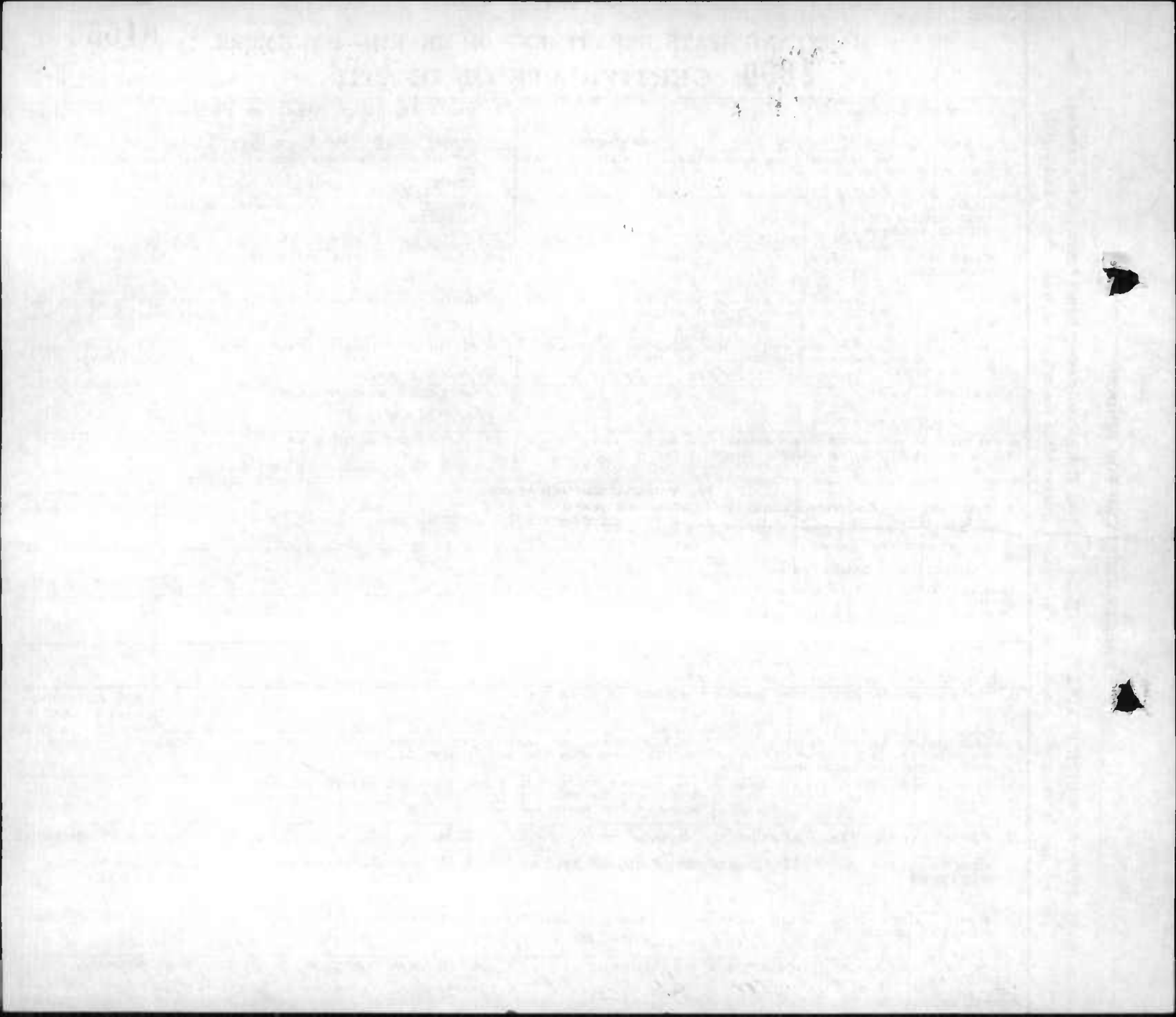
FEB 16 1952

BUREAU V. S.

1399 CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u> MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>51 ARBUTHUS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>51 ARBUTHUS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5554 SOUTHWESTERN BLVD</u>		STREET ADDRESS (If rural give location) <u>5554 SOUTHWESTERN BLVD.</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last) <u>CHARLES F. STRASSER</u>		OF DEATH: <u>FEB. 4</u> 19 <u>56</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED.	8. DATE OF BIRTH:
<u>MALE</u>	<u>WHITE</u>	<u>MARRIED</u>	<u>MAY 12, 1895</u>
9. AGE last birthday		IF UNDER 1 YEAR	
<u>80</u> yrs.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>LETTER CARRIER</u>		<u>POST OFFICE</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>MARYLAND</u>		<u>UNKNOWN</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>UNKNOWN</u>		<u>UNKNOWN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>NO</u>		<u>218-14-9468</u>	
17. INFORMANT & ADDRESS:		<u>ANNA K. STRASSER 5554 SOUTHWESTERN BLVD</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Myocardial Failure</u>			<u>3 days</u>
ANTECEDENT CAUSE (B) <u>Arterio Sclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1936, to Feb 4, 1956, that I last saw the deceased alive on Feb 4, 1956, and that death occurred at 6 P M, from the causes and on the date stated above.			
SIGNATURE <u>Frederic V. Beeter</u>		DATE SIGNED <u>M.D. 1014 Travis Ave - Baltimore - 2612</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>LONDON PARK</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 7, 1956</u>		24. FUNERAL DIRECTOR ADDRESS <u>1328 Lupton Dr. Rd.</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1559 CERTIFICATE OF DEATH

01537
35

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Parkton</u>				c. LENGTH OF STAY IN 1b <u>20 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>York Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Robert W. Strawbridge</u>				4. DATE OF DEATH <u>February 25, 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 18, 1866</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>New Park, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James Strawbridge</u>				14. MOTHER'S MAIDEN NAME <u>Eliza Shirey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Mrs. Simon Waltemyer, Parkton, Md. R. D.</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb. 22, 1956</u> , to <u>Feb. 25, 1956</u> , that I last saw the deceased alive on <u>Feb. 25, 1956</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. France</u> M.D.				ADDRESS (Street, city or town, state) <u>Parkton, Md.</u> DATE SIGNED <u>2/26/56</u>			
PHYSICIAN'S NAME (Type) <u>Dr. A. M. France</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Febr. 28, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Center Presby. Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>New Park, York Co., Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Jacob Herkenstein</u> ADDRESS <u>New Freedom, Pa.</u>				24a. REC'D BY REGISTRAR <u>—</u> DATE <u>2/26/56</u>		24b. REGISTRAR'S SIGNATURE <u>Charles J. Fullon</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

BUREAU V. S.

MAR 6 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 4/4

1560

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY ANNE ARUNDEL
CITY (If outside corporate limits, write RURAL OR and give nearest town) FORT HOWARD	LENGTH OF STAY (in this place) 93 Days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN GLEN BURNIE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS (If rural give location) PT. PLEASANT, RT. 2, BOX 147	
3. NAME OF DECEASED: (First) GEORGE (Middle) J. (Last) STROHMER		4. DATE (Month) (Day) (Year) OF DEATH FEBRUARY 19 1956	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: April 25, 1890
9. AGE last birthday 65 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper (Boiler maker)		10B. KIND OF BUSINESS OR INDUSTRY: Steel Co.	11. BIRTHPLACE (State or foreign country): Baltimore, Maryland
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME: John Strohmer	
14. MOTHER'S MAIDEN NAME: Catherine Kunkle		15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW I	
16. SOCIAL SECURITY NO. 213-16-3548		17. INFORMANT & ADDRESS: V Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE 610X		(A) BILATERAL HYDRONEPHROSIS AND PYELONEPHRITIS	
ANTECEDENT CAUSE (S)		DUE TO BENIGN PROSTATIC HYPERTROPHY	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST		(B) DUE TO	
		(C) DUE TO	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 3 2/13/56		19B. MAJOR FINDINGS OF OPERATION: Transurethral Resection of Prostate	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov. 18, 1955 to Feb. 19, 1956 , that I last saw the deceased alive on Feb. 19, 1956 , and that death occurred at 2:50 P.M. from the causes and on the date stated above.			
SIGNATURE D. D. MARK, M.D.		ADDRESS M. D. VAH, FORT HOWARD, MARYLAND	
DATE SIGNED 2-20-56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2-22-56	
NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR 2-21-56		REGISTRAR'S SIGNATURE George Schwab	
FUNERAL DIRECTOR George Schwab		ADDRESS George Schwab Funeral Home, 2101 Frederick Ave., Baltimore, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

IN SENATE

January 1, 1900

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1899

ALBANY:

1900

PRINTED BY THE

UNIVERSITY OF THE STATE OF NEW YORK

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ALBANY

1389

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MD. COUNTY BALTO.	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN DUNDALK (22)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN DUNDALK 22	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2604 YORKWAY		STREET ADDRESS (If rural, give location) 2604 YORKWAY	
3. NAME OF DECEASED (Type or Print) (First) ORVILLE (Middle) RUSSELL (Last) SWANN		4. DATE OF DEATH (Month) 2 (Day) 9 (Year) 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH 16 MAY 1902
9. AGE last birthday 53 yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WELDER		10b. KIND OF BUSINESS OR INDUSTRY SHIP REPAIR	
11. BIRTHPLACE (State or foreign country) W. VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SWANN		14. MOTHER'S MAIDEN NAME ANNA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-09-9489	
17. INFORMANT BESSIE B. SWANN		- WIDOW	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) Coronary Occlusion		2 hours
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
BURIAL	2-13-56	ODD FELLOWS CEM.	SMYRNA, DEL.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR?

ADDRESS

Feb 12 - 1956 William M. Kelly With Ruth Bradley, Dundalk, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 14 1964

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01540

Item 21 Film G193 2-29-56 ams

Item 12, Film G193 2-27-56 et

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH COUNTY BALTIMORE CITY (If outside corporate limits, write RURAL and give nearest town) Fullerton TOWN Fullerton HOSPITAL OR INSTITUTION OR STREET ADDRESS		MARYLAND LENGTH OF STAY (in this place)		2. USUAL RESIDENCE (HOME) OF DECEASED STATE MD. COUNTY BALTIMORE CITY (If outside corporate limits, write RURAL and give nearest town) BALTIMORE TOWN BALTIMORE STREET ADDRESS (If rural, give location) 9223 BELAIR ROAD.	
3. NAME OF DECEASED (First) (Middle) (Last) STANISLAWA-ELIZABETH-SZYNKIELENSKI		4. DATE OF DEATH 2 - 14 1956		5. SEX FEMALE	
6. COLOR OR RACE WHITE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWED		8. DATE OF BIRTH	
9. AGE last birthday 75 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME	
14. MOTHER'S MAIDEN NAME UNK.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS W. C. Wilhelm, Daughters					

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Pulmonary Embolism		3 hrs.
Antecedent cause(s) (b) Inter trochanteric fracture of hip		5 wks.
(c) resulting in phlebotomy toxic		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION 10 Jan. 56	19b. MAJOR FINDINGS OF OPERATION Pinned - Intertrochanteric fracture	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>

21. ACCIDENT (Specify) Accident	PLACE (Home, farm, factory, street, office bldg., etc.) Home	(CITY OR TOWN) Fullerton	(COUNTY) Balto.	(STATE) Md.
TIME (Month) (Day) (Year) (Hour) INJURY Jan 9 56 7a m.	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? Slipped in bedroom on bare floor & fell down on tank vacuum cleaner.		

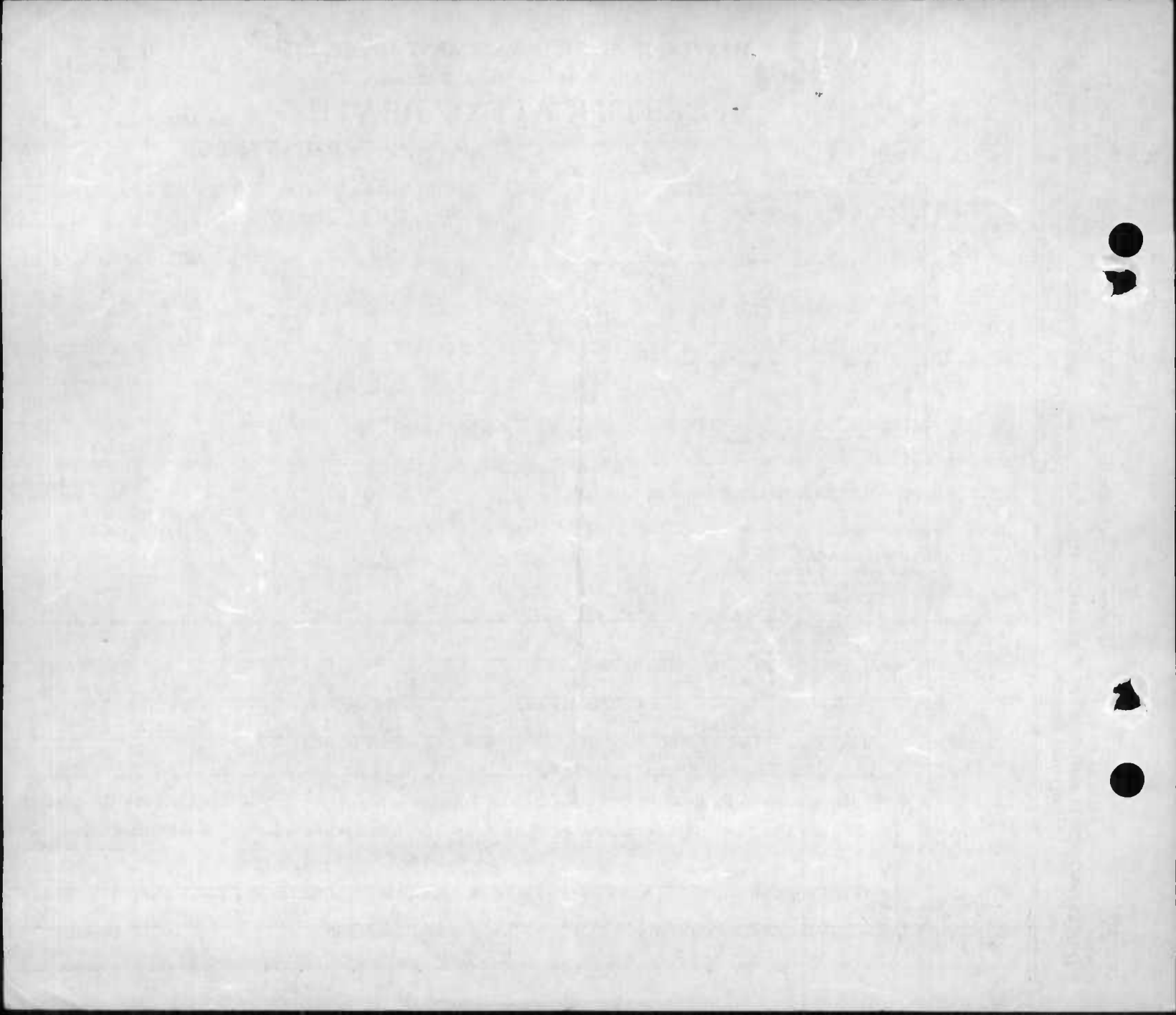
22. I hereby certify that I attended the deceased from **9 Jan, 1956**, to **14 Feb, 1956**, that I last saw the deceased alive on **14 Feb, 1956**, and that death occurred at **8:30 A.M.**, from the causes and on the date stated above.

SIGNATURE John C. Dykema	(Degree or title)	ADDRESS 7527 Belair Rd Balto, Md	DATE SIGNED 2/15/56
23. BURIAL, CREMATION REMOVAL (Specify) BURIAL	DATE THEREOF 2/17/56	NAME OF CEMETERY OR CREMATORY HOLY CROSS CEM.	LOCATION (City, town, or county) BALTIMORE
DATE REC'D BY LOCAL REG. 2-15-56	REGISTRAR'S SIGNATURE John C. Dykema	24. FUNERAL DIRECTOR Fred W. Orazowski	ADDRESS 1930 Easton Ave.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1562

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>X</u> <u>Jones Creek</u>				<u>Jones Creek</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7402 Hammond Road</u>				STREET ADDRESS (If rural give location) <u>7402 Hammond Road</u>			
3. NAME OF DECEASED: (First) <u>MARY</u>		(Middle) <u>E.</u>		(Last) <u>TRACEY</u>		4. DATE OF DEATH: (Month) <u>Feb.</u> (Day) <u>8,</u> (Year) <u>1956</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Jan. 27, 1900</u>	
				9. AGE last birthday: <u>56</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>At home</u>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>	
13. FATHER'S NAME: <u>John Doster</u>				14. MOTHER'S MAIDEN NAME: <u>Gillard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u>		(If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Joseph A. Tracey 7402 Hammond Road.</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
420.0 Immediate cause (a) <u>Coronary Thrombosis</u>						3 months	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Hypertensive Arteriosclerosis Heart Disease</u>						?	
(c) <u>Bronchial Asthma</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY ?				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct. 25, 1955</u> , to <u>Feb. 8, 1956</u> , that I last saw the deceased alive on <u>Feb. 2, 1956</u> , and that death occurred at <u>9:20 PM, 2/8/56</u> from the causes and on the date stated above.							
SIGNATURE <u>Daniel Owens M. D.</u>		(Degree or title)		ADDRESS <u>914 D Street Bkts. 19</u>		DATE SIGNED <u>2/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 11, 1956</u>		<u>Oak Lawn</u>		<u>Colgate, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>February 9, 1956</u>		<u>Dawson L. Farber</u>		<u>Ullrich Funeral Home</u>		<u>2112 Dundalk Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 14 1956

RECEIVED

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TO ATTENDING PHYSICIAN & HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01542

1563 CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>md</i>	COUNTY <i>Balto</i>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>Parkton</i>	<i>10 yrs</i>	TOWN <i>Parkton</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (First) (Middle) (Last)		4. DATE OF DEATH (Month) (Day) (Year)	
<i>RICHARD</i>		<i>Feb. 23</i> 19 <i>56</i>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<i>M</i>	<i>White</i>	<i>Widowed</i>	<i>Jan 28-1975</i>
9. AGE last birthday		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
<i>81</i> yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<i>Retired</i>		<i>Farm.</i>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<i>md</i>		<i>USA</i>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
<i>Jacob Tracey</i>		<i>Martha Egging</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
<i>no</i>		<i>no</i>	
17. INFORMANT & ADDRESS			
<i>Mrs Ralph Loretta. Parkton md</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
332X IMMEDIATE CAUSE (A)		<i>Cerebral Thrombosis</i>	
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE			
STATING UNDERLYING CAUSE LAST. DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Feb. 20</i>, 19<i>56</i>, to <i>Feb. 23</i>, 19<i>56</i>, that I last saw the deceased alive on <i>Feb. 23</i>, 19<i>56</i>, and that death occurred at <i>8P</i> M, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
<i>R. M. France</i> M.D.		<i>Parkton md</i> 2/23/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<i>Burial</i>		<i>St Abrahams Luth</i>	
24. REC'D BY REGISTRAR		LOCATION (City, town, or county) (State)	
REGISTRAR'S SIGNATURE		<i>Balto Co md</i>	
<i>Mrs Howard S. Markblaine</i>			
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>Edw C Tipton</i>		<i>Hampstead Md</i>	
DATE <i>2-28-56</i>			

1950 CERTIFICATE OF DEATH

Reg. No. 11-1-1

1. DECEASED PERSON'S NAME (Last, first, middle initial)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF CLERGYMAN

17. SIGNATURE OF BURIAL OFFICIAL

18. SIGNATURE OF INTERVIEWER

19. SIGNATURE OF CORONER

20. SIGNATURE OF JURY

21. SIGNATURE OF JUDGE

22. SIGNATURE OF DISTRICT ATTORNEY

23. SIGNATURE OF COUNTY CLERK

24. SIGNATURE OF TOWNSHIP CLERK

25. SIGNATURE OF VOTING BOARD

26. SIGNATURE OF SCHOOL BOARD

27. SIGNATURE OF BOARD OF EDUCATION

28. SIGNATURE OF BOARD OF SUPERVISORS

29. SIGNATURE OF BOARD OF COMMISSIONERS

30. SIGNATURE OF BOARD OF ESTIMATES

31. SIGNATURE OF BOARD OF PUBLIC WORKS

32. SIGNATURE OF BOARD OF PUBLIC UTILITIES

33. SIGNATURE OF BOARD OF PUBLIC SAFETY

34. SIGNATURE OF BOARD OF PUBLIC HEALTH

35. SIGNATURE OF BOARD OF PUBLIC WELFARE

36. SIGNATURE OF BOARD OF PUBLIC MORALS

37. SIGNATURE OF BOARD OF PUBLIC ORDER

38. SIGNATURE OF BOARD OF PUBLIC DECENCY

39. SIGNATURE OF BOARD OF PUBLIC PROPERTY

40. SIGNATURE OF BOARD OF PUBLIC REPUTATION

41. SIGNATURE OF BOARD OF PUBLIC RESPECT

42. SIGNATURE OF BOARD OF PUBLIC SAFETY

43. SIGNATURE OF BOARD OF PUBLIC SECURITY

44. SIGNATURE OF BOARD OF PUBLIC SUSTAINMENT

45. SIGNATURE OF BOARD OF PUBLIC TENDENCY

46. SIGNATURE OF BOARD OF PUBLIC TRUTH

47. SIGNATURE OF BOARD OF PUBLIC VIRTUE

48. SIGNATURE OF BOARD OF PUBLIC WISDOM

BUREAU V. S.

MAR 2 1950

RECEIVED

INSTRUCTIONS

1. This form is to be filled out by the physician or other qualified person who has attended the deceased. It should be filled out as soon as possible after death, and should be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland. It is the duty of the physician or other qualified person to fill out this form, and to sign it. It is the duty of the Registrar to file this form, and to issue a certificate of death. It is the duty of the coroner to fill out this form, and to sign it. It is the duty of the jury to fill out this form, and to sign it. It is the duty of the judge to fill out this form, and to sign it. It is the duty of the district attorney to fill out this form, and to sign it. It is the duty of the county clerk to fill out this form, and to sign it. It is the duty of the township clerk to fill out this form, and to sign it. It is the duty of the voting board to fill out this form, and to sign it. It is the duty of the school board to fill out this form, and to sign it. It is the duty of the board of education to fill out this form, and to sign it. It is the duty of the board of supervisors to fill out this form, and to sign it. It is the duty of the board of commissioners to fill out this form, and to sign it. It is the duty of the board of estimates to fill out this form, and to sign it. It is the duty of the board of public works to fill out this form, and to sign it. It is the duty of the board of public utilities to fill out this form, and to sign it. It is the duty of the board of public safety to fill out this form, and to sign it. It is the duty of the board of public health to fill out this form, and to sign it. It is the duty of the board of public welfare to fill out this form, and to sign it. It is the duty of the board of public morals to fill out this form, and to sign it. It is the duty of the board of public order to fill out this form, and to sign it. It is the duty of the board of public decency to fill out this form, and to sign it. It is the duty of the board of public property to fill out this form, and to sign it. It is the duty of the board of public reputation to fill out this form, and to sign it. It is the duty of the board of public respect to fill out this form, and to sign it. It is the duty of the board of public safety to fill out this form, and to sign it. It is the duty of the board of public security to fill out this form, and to sign it. It is the duty of the board of public sustenance to fill out this form, and to sign it. It is the duty of the board of public tendency to fill out this form, and to sign it. It is the duty of the board of public truth to fill out this form, and to sign it. It is the duty of the board of public virtue to fill out this form, and to sign it. It is the duty of the board of public wisdom to fill out this form, and to sign it.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01543

1564 CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Freeland		CITY (If outside corporate limits, write RURAL and give nearest town) Freeland	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) Michalina	(Middle) R.	(Last) Trczinski (Taylor)
4. DATE OF DEATH	(Month) Feb.	(Day) 2	(Year) 1956
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Sept. 1884
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Poland
13. FATHER'S NAME John Ratajizak		14. MOTHER'S MAIDEN NAME Ida	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. 212-09-0429A	17. INFORMANT AND ADDRESS Mrs Marie Froelich Freeland, Maryland

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
(a) Immediate cause Cerebral Hemorrhage			10 days
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last Arteriosclerosis			10 years
(c) 11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Rheumatoid Arthritis			15 years
19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION none	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 23, 1956 , to Feb. 1, 1956 , that I last saw the deceased alive on Feb. 1, 1956 , and that death occurred at 3:00 p.m. , from the causes and on the date stated above.			
SIGNATURE Louis Schatanoff M.D.		ADDRESS New Freedom, Pa.	DATE SIGNED 2/2/56
23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE THEREOF Feb. 6, 1956	NAME OF CEMETERY OR CREMATORY St. Stanislaus	LOCATION (City, town, or county) (State) Baltimore, Maryland
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS Lilly, & Zeiler Inc., 403 S. Wolfe St.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1085

1085



CERTIFICATE OF DEATH

Reg. Dist. No. 43

1565

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Balto.	MARYLAND	STATE Md.	COUNTY Balto.
CITY (If outside corporate limits, write RURAL OR and give nearest town) Overlea	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) Overlea	
HOSPITAL, OR INSTITUTION OR STREET ADDRESS 7 Fuller Ave.		STREET ADDRESS (If rural give location) 7 Fuller Ave.	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
Burleigh E. Turner		Feb. 26, 1956	
5. SEX: M.	6. COLOR OR RACE: W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH 1889 Dec. 14, 1890
		9. AGE last birthday 66 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		10B. KIND OF BUSINESS OR INDUSTRY: Hotel	11. BIRTHPLACE (State or foreign country): Virginia
13. FATHER'S NAME: Unknown		14. MOTHER'S MAIDEN NAME: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 216-09-8274	
		17. INFORMANT & ADDRESS: (Wife) 7 Fuller Ave.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Coronary thrombosis			10 days
ANTECEDENT CAUSE (S) DUE TO (B) Arteriosclerotic coronary			2 yrs.
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) Heart disease			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb 20, 1954 to Feb 25, 1956 that I last saw the deceased alive on Feb 25, 1956 and that death occurred at 8:30 P.M. from the causes and on the date stated above.			
SIGNATURE Charles M. Kerr		ADDRESS 6801 Belair Rd DATE SIGNED Feb 28, 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF Feb. 28, 56	
		NAME OF CEMETERY OR CREMATORY Parkwood Cam.	
		LOCATION (City, town, or county) (State) Balto. Md.	
DATE REC'D BY LOCAL REGISTRAR 2-27-56		REGISTRAR'S SIGNATURE DW Hedger	
		24. FUNERAL DIRECTOR Paul A. Heemann ADDRESS 6067 Harford Rd.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CONFIDENTIAL

At 11:11
6801 10/10/11

1566

02505

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL
OR and give nearest town)
TOWNLENGTH OF STAY
(in this place)HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTYCITY (If outside corporate limits write RURAL and give nearest town)
OR
TOWN

STREET ADDRESS (If rural, give location)

3. NAME OF
DECEASED:
(Type or Print)

(First)

(Middle)

(Last)

Unidentified Newborn4. DATE OF DEATH (Month) (Day) (Year)
2 1 56

5. SEX:

Female6. COLOR OR
RACE:White7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

8. DATE OF BIRTH:

9. AGE last birthday:
yrs.IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min.10a. USUAL OCCUPATION (Give kind of
work done during most of work life,
even if retired):10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN
ONSET AND DEATH

Immediate cause

(a) Anoxia secondary to placenta praevia.

DUE TO

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause DUE TO
stating underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING
TO THE DEATH BUT NOT RELATED TO THE
DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?
Yes ☒ No ☐21a. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.21b. PLACE (Home, farm, factory,
OF street, office bldg., etc.,
INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour)
OF INJURY Found XXXX XXXX XXXX21e. INJURY OCCURRED
While at Not while
work ☐ at work ☒

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and
find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
M. D. ASSISTANT MEDICAL EXAM. ☒

DATE SIGNED

2/2/5623. BURIAL, CREMATION,
REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
APR 3 1955
BUREAU V. S.

1567

CERTIFICATE OF DEATH

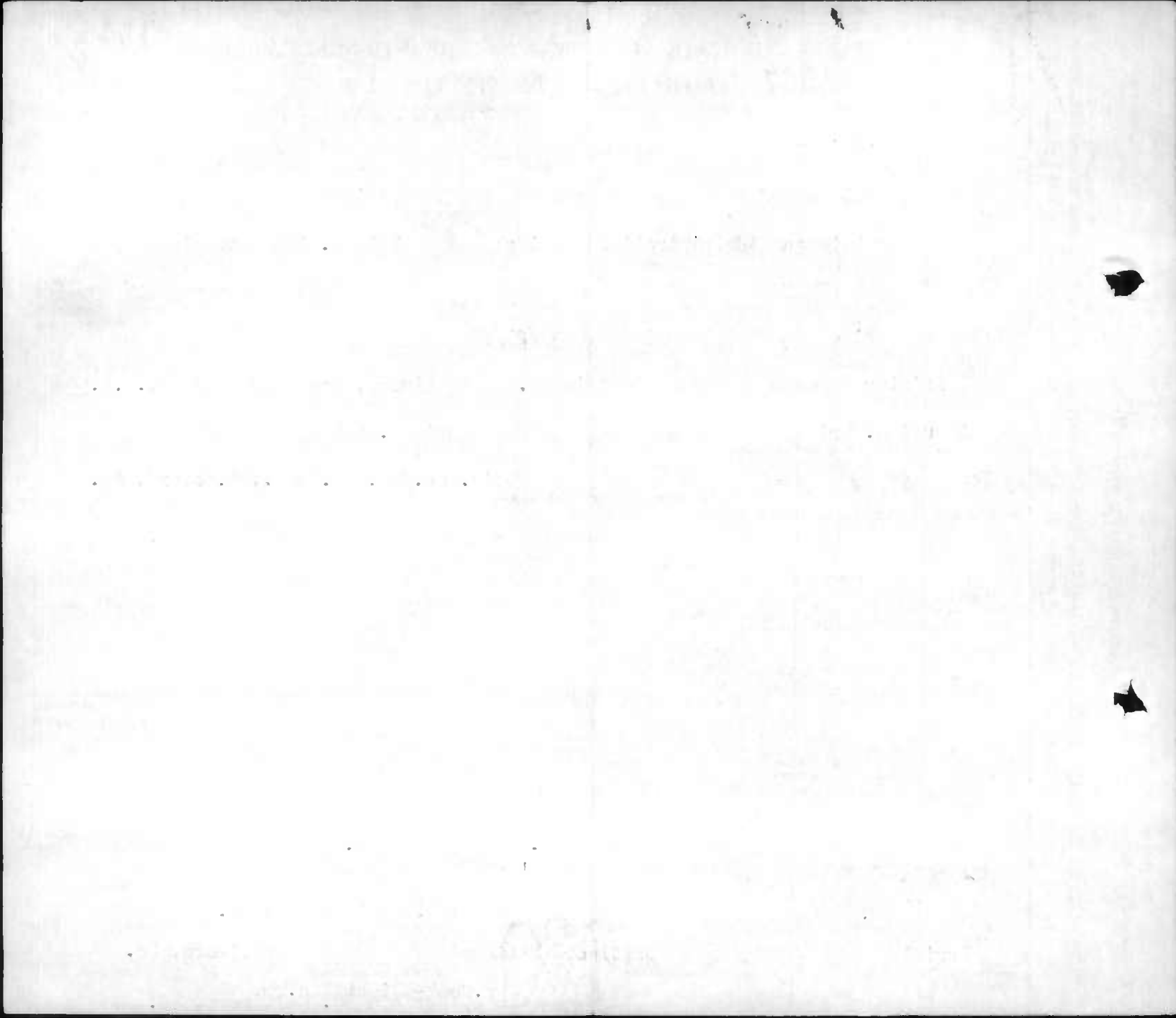
Reg. Dist. No.

44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore (6)			
X TOWN Fort Howard		9 Days		STREET ADDRESS (If rural give location) 7913 E. 30th Street			
50 HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital							
3. NAME OF DECEASED: (First) PERCY		(Middle) (NMI)		(Last) URIE		4. DATE (Month) (Day) (Year) OF DEATH: February 25 19 56	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: 9/23/95	9. AGE last birthday: 60 yrs.	IF UNDER 1 YEAR: Months	IF UNDER 24 HRS.: Days	IF UNDER 24 HRS.: Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if Painter Foreman		10B. KIND OF BUSINESS OR INDUSTRY: Gas & Electric Co.		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Samuel H. Urie				14. MOTHER'S MAIDEN NAME: Annie V. Downey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. 212-05-5133		17. INFORMANT & ADDRESS: Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
IMMEDIATE CAUSE (A) 292.4 APLASTIC ANEMIA							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Feb. 16, 1956 , to Feb. 25, 1956 , and that death occurred at 8:25 PM , from the causes and on the date stated above.							
SIGNATURE D. MARK		M. D. VAH, Fort Howard, Md.		ADDRESS		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2-29-56		NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR 2/27/56		REGISTRAR'S SIGNATURE A. H. Hedrick		24. FUNERAL DIRECTOR Wm. Cook-Blight, Inc.		ADDRESS 6009 Harford Rd. Baltimore, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

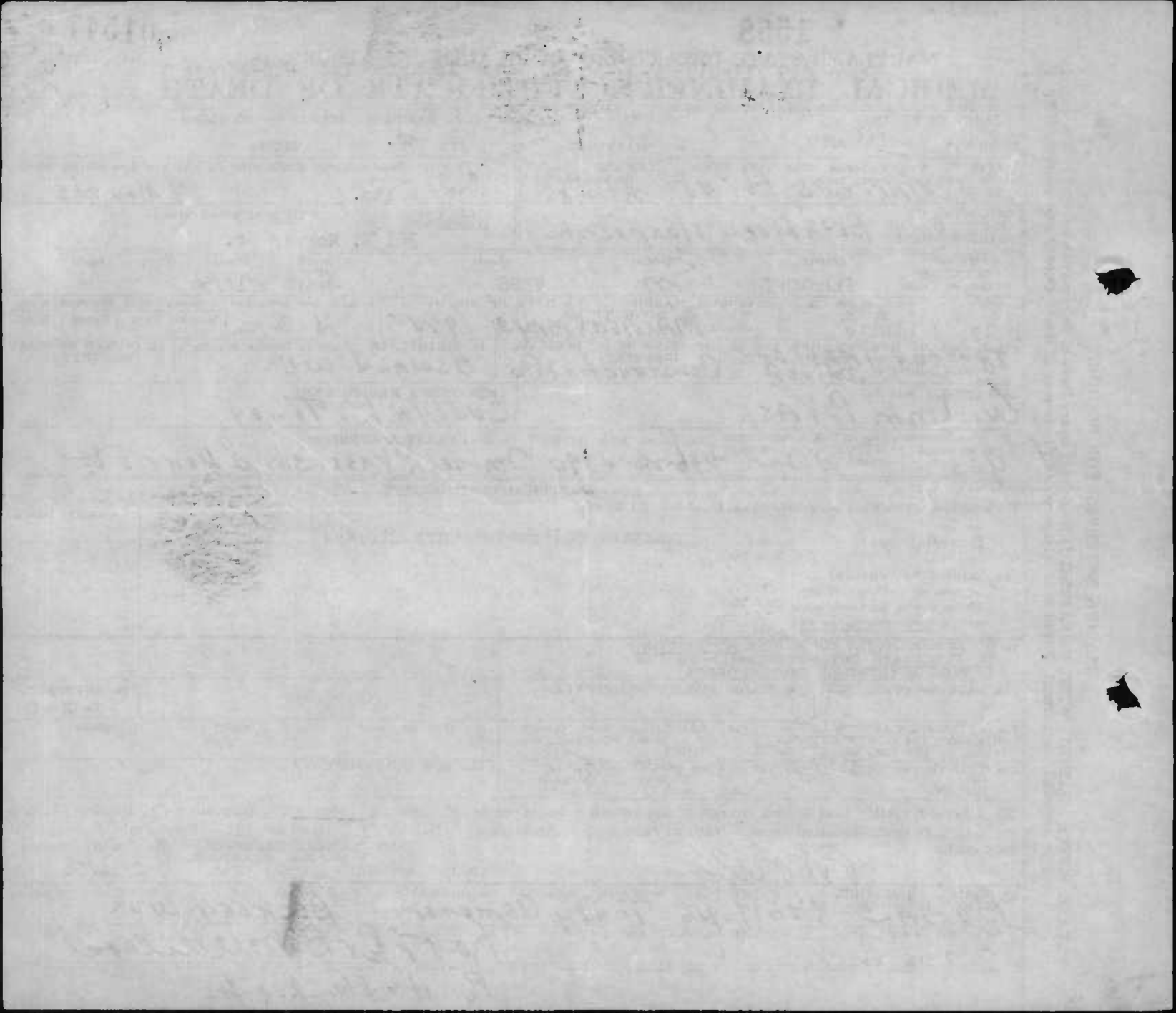
1568
MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01547

Reg. Dist.

No. 47

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>SHARROWS POINT</u>		LENGTH OF STAY (in this place) <u>2 Hours</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Balto.</u>		<u>7 Months</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>BETH STEEL HOSPITAL</u>				STREET ADDRESS (If rural, give location) <u>301 S. Norris St.</u>			
3. NAME OF DECEASED: (First) <u>ELLSWORTH</u> (Middle) <u>M.</u> (Last) <u>VASS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>2/14/56</u> <u>19</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>MARRIED</u>	8. DATE OF BIRTH: <u>MAY 31 - 1925</u>	9. AGE last birthday: <u>30</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work, if any, even if retired): <u>DRIVER</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>CONSTRUCTION Co</u>		11. BIRTHPLACE (State or foreign country): <u>OSWALD W. VA</u>	
13. FATHER'S NAME: <u>WILLIAM P. VASS</u>				14. MOTHER'S MAIDEN NAME: <u>EVELYN R. TONEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>YES</u>				16. SOCIAL SECURITY No.: <u>WWY X36-26-4890</u>		17. INFORMANT & ADDRESS: <u>FRANCIS R. VASS 301 S. NORRIS ST</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Arteriosclerotic heart disease</u>							
DUE TO							
Antecedent cause(s) (b)							
Diseases or conditions, if any, giving rise to the above cause DUE TO							
stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>R. H. Fisher</u>		M. D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>2/14/56</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>		DATE THEREOF: <u>Feb 17 - 1956</u>		NAME OF CEMETERY OR CREMATORY: <u>TONEY CEMETERY</u>		LOCATION (City, town, or county) (State): <u>BECKLEY WVA</u>	
DATE REC'D BY LOCAL REG. <u>2-15-56</u>		REGISTRAR'S SIGNATURE <u>L</u>		24. FUNERAL DIRECTOR: <u>Harry B. M. Walters</u>		ADDRESS: <u>PRA H & Stricker Sts</u>	



01548

STATE DEPARTMENT OF HEALTH

MARYLAND

1569

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
TOWN <u>Pikesville</u>		TOWN <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1703 Kenturton Rd.</u>		STREET ADDRESS (If rural, give location) <u>1703 Kenturton Rd.</u>	
3. NAME OF DECEASED (Type or Print) <u>DELDHINE ELIZABETH VAUGHN</u>		4. DATE OF DEATH (Month) <u>February</u> (Day) <u>14</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>October 11, 1921</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>34</u> yrs. If under 1 year Months Days Hours Min
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Melvin Harmon</u>		14. MOTHER'S MAIDEN NAME <u>Russell Mae Morris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>219-28-9073</u>	
17. INFORMANT AND ADDRESS <u>Mr. Edward Vaughn, 1703 Kenturton Rd. Pikesville, Md.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause <u>Carcinoma, cervix with generalized metastasis</u>		(b) Antecedent cause(s) <u>metastasis</u>	
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(d) Other significant conditions	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		(CITY OR TOWN) (COUNTY) (STATE)	
22. I hereby certify that I attended the deceased from <u>October 20, 1955</u> , to <u>Feb 14, 1956</u> , that I last saw the deceased alive on <u>Feb 13, 1956</u> , and that death occurred at <u>1:10 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Charles S. McWilliam</u>		DATE SIGNED <u>February 14, 1956</u>	
(Degree or title)		(Address)	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>Feb. 18, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Sater's Baptist Cemetery</u>		LOCATION (City, town, or county) (State) <u>Lutherville, Balto. Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>Feb. 21, 1956 Dorothy Newell</u>		7. FUNERAL DIRECTOR <u>John Burns Sons</u> ADDRESS <u>Towson, Maryland</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

FEB 29 1932

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

01549

1570 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baysville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1804 Kirkwood Court</u>		STREET ADDRESS (If rural, give location) <u>1559 Homestead Street #18</u>	
3. NAME OF DECEASED (Type or Print) <u>Mrs. Josephine B. Walther</u>		4. DATE OF DEATH <u>February 18th 1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Mar. 1, 1899</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>56</u> yrs. <u>February 18th 1956</u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown (Stein)</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Mr. August Michael Walther, 1559 Homestead</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary Occlusion</u>		<u>Sudden</u>
Antecedent cause(s) (b) <u>Hypertensive Cardio-Renal</u>		
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Vascular Disease</u>		<u>5 yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? <input type="checkbox"/> Yes <input type="checkbox"/> No
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

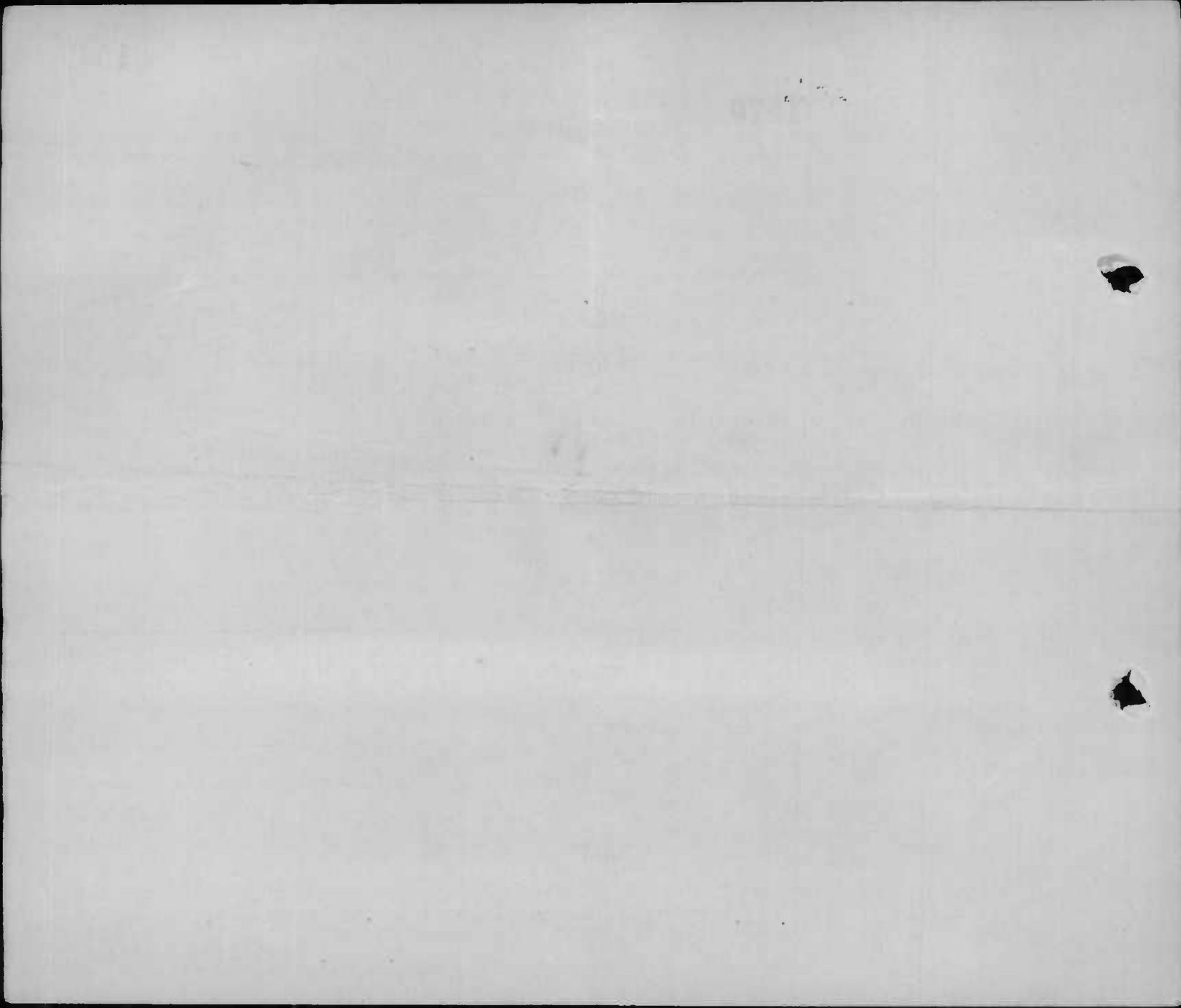
22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Feb. 21, 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cem.</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
DATE RECEIVED BY LOCAL REG. <u>Feb 20 1956</u>	REGISTRAR'S SIGNATURE <u>H. W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Leonard J. Ruck, 5305 Harford Road #14</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01550

1400 CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Arbutus</u>				TOWN <u>Arbutus</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1050 Downton Rd.</u>				STREET ADDRESS (If rural give location) <u>1050 Downton Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>George</u> (Middle) <u>E.</u> (Last) <u>Ward</u>				(Month) <u>Feb.</u> (Day) <u>4</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M.</u>	<u>W.</u>	<u>Divorced</u>	<u>Jan. 29, 1898</u>	<u>58</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Machinist</u>		<u>B&O Railroad</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Thomas Ward</u>				<u>Laura</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Mrs Doris Ruediger, 1050 Downton Rd.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
334X IMMEDIATE CAUSE (A)				<u>Arteriosclerotic Encephalopathy</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>with Cerebral Arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>9 Months</u>			
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Broncho pneumonia Bilateral</u>			
19a. DATE OF OPERATION				20. AUTOPSY?			
<u>Dec. 1955</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?			
<u>Arteriosclerotic Encephalopathy</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JANUARY 6 1956</u> , to <u>FEBRUARY 4 1956</u> , that I last saw the deceased alive on <u>Feb. 4</u> , 19 <u>56</u> , and that death occurred at <u>5:40 P.</u> M, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>Melvin N. Borden</u>				<u>5000 Old Frederick Rd Balt 29 2/7/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Feb. 8/56</u>		<u>Loudon Park</u>		<u>Balto. Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>FEB 8 1956</u>		<u>Dr. Geo. S. McLaughlin</u>		<u>Harry H. Witzke</u>		<u>4101 Edmondson Ave.</u>	

CERTIFICATE OF DEATH

Reg. No. 1-10

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. PLACE OF BIRTH

9. OCCUPATION

10. MARITAL STATUS

11. COLOR

12. EDUCATION

13. RELIGION

14. SERVICE

15. DATE OF BIRTH

16. PLACE OF BIRTH

17. OCCUPATION

18. TIME OF BIRTH

19. CAUSE OF BIRTH

20. PLACE OF BIRTH

21. OCCUPATION

22. MARITAL STATUS

23. COLOR

24. EDUCATION

25. RELIGION

26. SERVICE

27. DATE OF BIRTH

28. PLACE OF BIRTH

29. OCCUPATION

30. TIME OF BIRTH

31. CAUSE OF BIRTH

32. PLACE OF BIRTH

33. OCCUPATION

34. MARITAL STATUS

35. COLOR

36. EDUCATION

37. RELIGION

38. SERVICE

39. DATE OF BIRTH

40. PLACE OF BIRTH

41. OCCUPATION

42. TIME OF BIRTH

43. CAUSE OF BIRTH

44. PLACE OF BIRTH

45. OCCUPATION

46. MARITAL STATUS

47. COLOR

48. EDUCATION

49. RELIGION

50. SERVICE

51. DATE OF BIRTH

52. PLACE OF BIRTH

53. OCCUPATION

54. TIME OF BIRTH

55. CAUSE OF BIRTH

56. PLACE OF BIRTH

57. OCCUPATION

58. MARITAL STATUS

59. COLOR

60. EDUCATION

61. RELIGION

62. SERVICE

63. DATE OF BIRTH

64. PLACE OF BIRTH

65. OCCUPATION

66. TIME OF BIRTH

67. CAUSE OF BIRTH

68. PLACE OF BIRTH

69. OCCUPATION

70. MARITAL STATUS

71. COLOR

72. EDUCATION

73. RELIGION

74. SERVICE

75. DATE OF BIRTH

76. PLACE OF BIRTH

77. OCCUPATION

78. TIME OF BIRTH

79. CAUSE OF BIRTH

80. PLACE OF BIRTH

81. OCCUPATION

82. MARITAL STATUS

83. COLOR

84. EDUCATION

85. RELIGION

86. SERVICE

BUREAU V. S.

FEB 8 1936

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01551

1571

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Towson</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1836 Loch Shiel Road</u>				STREET ADDRESS (If rural give location) <u>1836 Loch Shiel Road</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>MAURICE HARDESTY WARD</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>February 3, 1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>October 30, 1888</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Ice Dealer: retired</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Self employed</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Asa Ward</u>				14. MOTHER'S MAIDEN NAME: <u>Ida E. Hardesty</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Mrs. Mattie P. Ward, Towson, Maryland</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>72 hrs</u>	
ANTECEDENT CAUSE (S) DUE TO (B) <u>Generalized Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Very premature for age</u>						<u>6 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 1949</u> , to <u>February 1956</u> that I last saw the deceased alive on <u>February 3 1956</u> , and that death occurred at <u>5:30 M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles F. O'Donnell</u>				ADDRESS <u>2501 Loch Rd - Towson</u>		DATE SIGNED <u>4th 2/5/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 6, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Towson, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2/7/56</u>		REGISTRAR'S SIGNATURE <u>A. M. Bacon</u>		24. FUNERAL DIRECTOR ADDRESS <u>John Burns' Sons, Towson, Maryland</u>			

BUREAU V. S.

FEB 9 1956

RECEIVED

INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OF HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01552

1572

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52</u> TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Owings Mills Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90</u> <u>House In The Pines</u> <u>16 Fusting Ave</u>				STREET ADDRESS (If rural give location) <u>Owings Mills Md.</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Grace</u> <u>E.</u> <u>Wareheim</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Feb.</u> <u>22</u> <u>1956</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Aug. 15, 1874</u>		9. AGE last birthday <u>81</u> yrs.		IF UNDER 1 YEAR Months Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H.W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>O.H.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Walsh</u>				14. MOTHER'S MAIDEN NAME <u>Mary Tucker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Md.</u> <u>Theodore E. Wareheim, Owings Mills</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
422.1 IMMEDIATE CAUSE (A) <u>ARTERIO SCLEROTIC CARDIO VASCULAR</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>DISEASE - CEREBRAL SCLEROSIS</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>TERMINAL PNEUMONIA - UREMIA</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>HYPERTROPHIC MYOCARDITIS</u>						INTERVAL BETWEEN ONSET AND DEATH 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/1</u>, 19<u>55</u>, to <u>2/22</u>, 19<u>56</u>, that I last saw the deceased alive on <u>2/22</u>, 19<u>56</u>, and that death occurred at <u>10:58</u> AM, from the causes and on the date stated above. SIGNATURE <u>John H. Shaw</u> M.D. <u>5800 Edmondson Ave</u> DATE SIGNED <u>2/24/56</u> ADDRESS (Street, city, town, state) (State)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 25/56</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		LOCATION (City, town, or county) <u>Pikesville Md.</u>	
24. REC'D BY REGISTRAR <u>FEB 27 1956</u>		REGISTRAR'S SIGNATURE <u>V. E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witzke</u>		ADDRESS <u>4101 Edmondson Ave</u>	

CERTIFICATE OF DEATH

Reg. Dist. No.

DEATH CERTIFICATE NUMBER OF PREDECESSOR

DATE OF DEATH

STATE

CITY

COUNTY

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

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BUREAU V. S.

DATE RECEIVED

FEB 27 1955

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01553

1573 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Parkville</u>				TOWN <u>Parkville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3011 Hiss Avenue</u>				STREET ADDRESS (If rural give location) <u>3011 Hiss Avenue</u>			
3. NAME OF DECEASED (Type or Print) <u>Mr. Lloyd A. Westley</u>				4. DATE OF DEATH (Month) <u>Feb.</u> (Day) <u>1,</u> (Year) <u>1956</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>		8. DATE OF BIRTH <u>May 25, 1886</u>	
9. AGE last birthday <u>69</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool & Dye Worker</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Henry Westley</u>				14. MOTHER'S MAIDEN NAME <u>Ida Raine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-10-9595</u>		17. INFORMANT & ADDRESS <u>Mrs. Mildred Westley, 3011 Hiss Ave.</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
420.1 IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arteriosclerotic CVD</u>						—	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/1</u> , 19 <u>55</u> , to <u>2/1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>2/1</u> , 19 <u>56</u> , and that death occurred at <u>9:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Harold A. Grott</u> M.D. <u>5100 Harford Rd</u>				DATE SIGNED <u>2/2/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb 4, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>Dr. A. M. Bacon</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, 5305 Harford Road #14</u>		ADDRESS	
DATE <u>FEB 3 1956</u>							

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01554

1574

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Balto.		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 55 TOWN Towson		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Towson 55			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1718 Redwood Ave.				STREET ADDRESS (If rural give location) 1718 Redwood Ave.			
3. NAME OF DECEASED: (First) (Middle) (Last) WILSON M. WHALEY				4. DATE (Month) (Day) (Year) OF DEATH: Feb. 10, 19 56			
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married	8. DATE OF BIRTH: Aug. 9, 1894	9. AGE last birthday: 61 yrs.	10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Draftsman			10B. KIND OF BUSINESS OR INDUSTRY: Bethlehem Steel		11. BIRTHPLACE (State or foreign country): Md.		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Edward N. Whaley				14. MOTHER'S MAIDEN NAME: Lillian M. Wilson			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: Mrs. Pearl D. Whaley - 1718 Redwood Ave	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE 331X (A) Massive Cerebral Hemorrhage						Instant	
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Slight Cerebral Hemorrhage						1949	
(C) Generalized Arteriosclerosis						?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Hypertension						?	
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 6-25-1954, to 2-10-1956 that I last saw the deceased alive on 2-10-1956, and that death occurred at 6:45 PM, from the causes and on the date stated above.							
SIGNATURE Robert H. Hiver		DATE THEREOF 2/13/56		NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		LOCATION (City, town, or county) Pikesville, Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE REC'D BY LOCAL REGISTRAR February 11 1956		REGISTRAR'S SIGNATURE R.W.		24. FUNERAL DIRECTOR ADDRESS ✓ Mrs. J. Dickerson & Sons. Balt. 171	

THE STATE OF NEW YORK
IN SENATE
January 10, 1900.
REPORT
OF THE
COMMISSIONER OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1899.
ALBANY:
J. B. LIPPINCOTT & CO. PRINTERS.
1900.

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ALBANY:
J. B. LIPPINCOTT & CO. PRINTERS.
1900.



01555

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

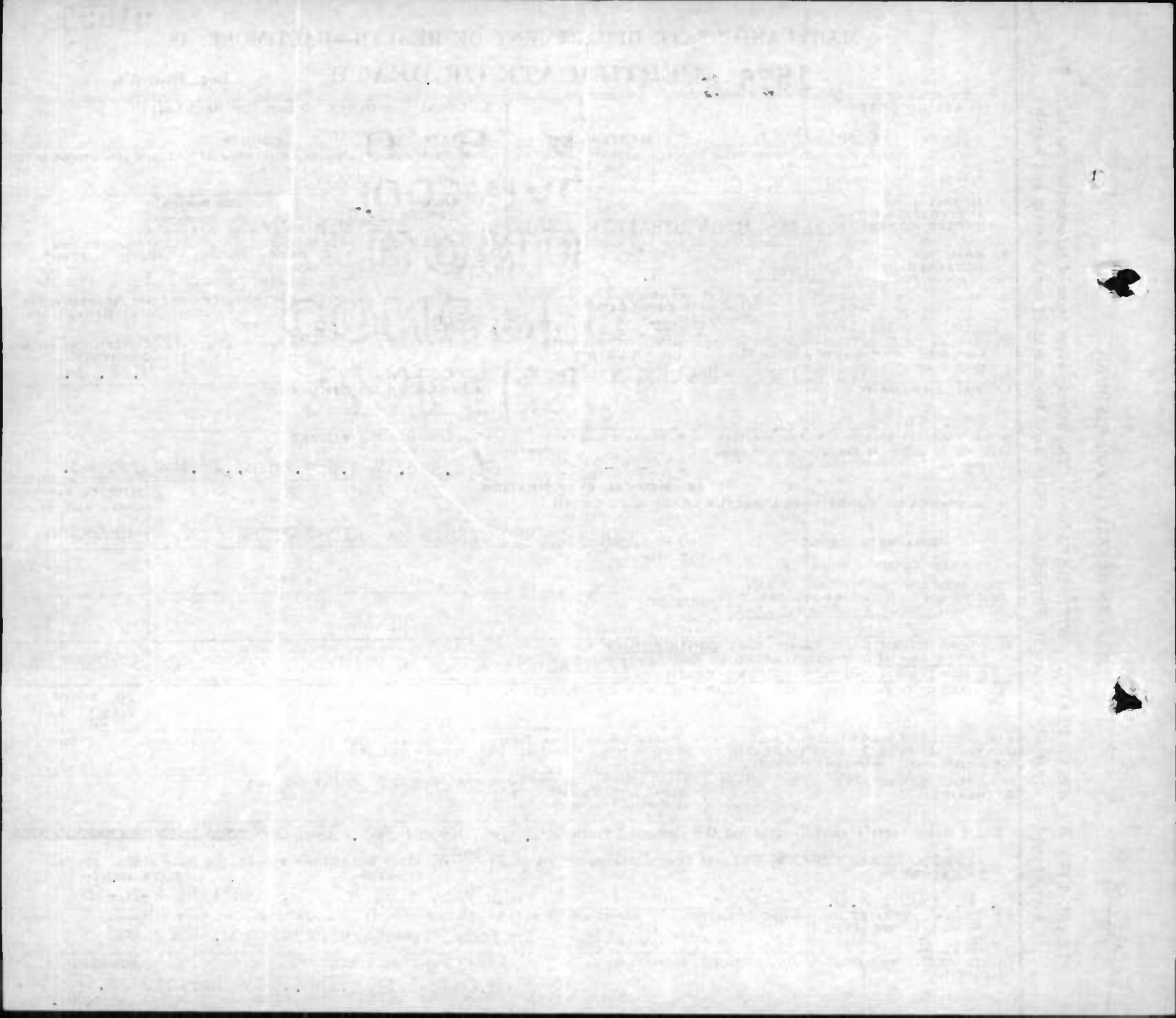
1575 CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>FORT HOWARD</u>		<u>12 Days</u>		TOWN <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>27 SOUTH PULASKI STREET</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>CHARLES R. WHITE</u>				<u>FEBRUARY 19 19 56</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>June 14, 1899</u>	
9. AGE last birthday <u>56</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Installer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Heating Equipment</u>		11. BIRTHPLACE (State or foreign country): <u>Frederick, Maryland</u>	
13. FATHER'S NAME: <u>James White</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Brady</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW I</u>				16. SOCIAL SECURITY NO. <u>216-05-2343</u>			
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>BRONCHOGENIC CARCINOMA, RIGHT UPPER LOBE</u>						UNKNOWN	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>002X</u>						(B) DUE TO	
						(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>BILATERAL FAR ADVANCED PULMONARY TUBERCULOSIS</u>						UNKNOWN	
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that <u>X</u> attended the deceased from <u>Feb. 7, 1956</u> , to <u>Feb. 19, 1956</u> and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>D. MARK, M.D.</u>				ADDRESS <u>M.D. VAH, FORT HOWARD, MARYLAND 2-20-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2-23-56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Feb 23, 1956</u>		REGISTRAR'S SIGNATURE <u>C.W. Hedlund</u>		24. FUNERAL DIRECTOR <u>Wm. Cook-Blight, Inc.</u>		ADDRESS <u>6009 Harford Rd., Balto. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G193 3-7-56 et.

CERTIFICATE OF DEATH

Reg. Dist. No.

01556

1576

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Daniels				c. LENGTH OF STAY IN 1b Daniels			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 107 Lower Brick Row				d. STREET ADDRESS 107 Lower Brick Row			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) WALTER PATTERSON WHITLEY				4. DATE OF DEATH Month Feb. Day 21 Year 1956			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1874	
9. AGE (In years last birthday) 81		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Cotton Mill Worker		11. BIRTHPLACE (State or foreign country) North Carolina	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-26-6696		17. INFORMANT James Shifflett Rt. 2 Elkton, Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) Arteriosclerotic Cardio-Vascular Disease				INTERVAL BETWEEN ONSET AND DEATH Immediate 2 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 10 , 19 54 , to Feb. 21 , 19 56 , that I last saw the deceased alive on Feb. 21 , 19 56 , and that death occurred at 5 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE William F. Gassaway M.D.				ADDRESS (Street, city or town, state) Ellicott City, Md.			
DATE SIGNED 2/21/56							
PHYSICIAN'S NAME (Type) William F. Gassaway				Ellicott City, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-24-56		22c. NAME OF CEMETERY OR CREMATORY Good Shepherd		22d. LOCATION (City, town, or county) (State) Ellicott City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md.				24. REC'D BY REGISTRAR FEB 27 1956			
24b. REGISTRAR'S SIGNATURE Dr. Wm. Martin							

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		Jan 1, 1910		New York City		Natural		Heart Disease		Jan 15, 1956		10:00 AM		Home		J. A. Smith		M. B. Jones	
Occupation		Education		Marital Status		Previous Illnesses		Last Medical Examination		Last Hospital Admission		Last Physician's Visit		Last Family Visit		Last Religious Service		Last Social Contact		Last Travel		Last Residence	
Teacher		High School		Married		None		1955		1955		1955		1955		1955		1955		1955		1955	
Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death	
Jan 15, 1956		10:00 AM		Home		J. A. Smith		M. B. Jones		Jan 15, 1956		10:00 AM		Home		J. A. Smith		M. B. Jones		Jan 15, 1956		10:00 AM	

FEB 27 1956

RECEIVED

BUREAU V. 1

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01557

Item 2, Film 192-2-11-56 et

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Balto.		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville/ Baltimore 3401-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Paradise Nursing Home		STREET ADDRESS (If rural give location) 3900 Edmondson Avenue Paradise & Myramont Aves. ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
IDA GERTRUDE WILEY				Feb. 8 19 56			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	white	married	Dec. 2, 1882	73 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
housewife			at home		Va.		
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
John R. Carroll				Amanda Schull			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
no		none		Mr. Roger C. Wiley - Balto., Md.			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) Cerebral vascular accident						15 minutes	
ANTECEDENT CAUSE (S): (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C) Anterior sclerosis, cerebral						Unknown	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12-16, 1955, to 2-8, 1956 that I last saw the deceased alive on 2-7, 1956, and that death occurred at 3:15 A.M., from the causes and on the date stated above.							
SIGNATURE		DATE THEREO		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Stephen J. Hagness		2/10/56		Moreland Mem. Pk.		Balto., Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
Burial		Feb 8, 1956		H. H. Hedrick		Wm. J. Tichner & Sons Balto. Md.	

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1578

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Dundalk</u>		53	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgeway Manor</u>				STREET ADDRESS (If rural give location) <u>2830 Southbrook Rd</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Bernard W Wilson</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>Feb 28 1956</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widow</u>		8. DATE OF BIRTH: <u>Feb 22 1898</u>	
9. AGE last birthday: <u>78</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Paper Hanger</u>				10b. KIND OF BUSINESS OR INDUSTRY:			
13. FATHER'S NAME: <u>Carl Wilson</u>				14. MOTHER'S MAIDEN NAME: <u>Louise Houston</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. Minnie Wilson 2830 Southbrook</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) <u>Congestive Heart Failure</u>						<u>2 days</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u>							
(c) <u>Carcinoma of Prostate</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 1956</u> , to <u>death</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Feb 26</u> , 19 <u>56</u> , and that death occurred at <u>7526 Halsted Ave</u> , from the causes and on the date stated above.							
SIGNATURE <u>Ronald Benoit MD</u>		(Degree or title)		ADDRESS <u>2112 Dundalk Ave</u>		DATE SIGNED <u>3/1/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town or county) (State)	
<u>Burial</u>		<u>Mar 3/56</u>		<u>Bethel Cem</u>		<u>Catonsville Md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR		ADDRESS <u>Widow's Fund Home 2112 Dundalk Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01559

Reg. Dist.

No. 33

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Penna.	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) Reisterstown, Md.	LENGTH OF STAY (in this place) 1 Week	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Philadelphia	758-3
HOSPITAL OR INSTITUTION OR STREET ADDRESS Bond Avenue Road		STREET ADDRESS (If rural, give location) 4530 Pine Street	
3. NAME OF DECEASED: (First) Hannah (Middle) B. (Last) Wilson		4. DATE OF DEATH (Month) (Day) (Year) Feb. 20 19 56	
5. SEX: F.	6. COLOR OR RACE: W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE	8. DATE OF BIRTH: April 3, 1886
9. AGE last birthday: 69 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life even if retired): Retired teacher		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME: John E. Wilson	
14. MOTHER'S MAIDEN NAME: Hannah B. Broomall		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If yes, give war or dates of service) no	
16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Fred Wilson Reisterstown, Md.	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) Coronary Occlusion			30 min.
Antecedent cause(s) (b) Arteriosclerotic C-V Disease			3 mos.
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. none			
19a. DATE OF OPERATION: none	19b. MAJOR FINDING OF OPERATION: none		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY none	21c. (City or town) (County) (State) none	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY none	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? none	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE D. D. Coples		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/> 2-21-56	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF Feb. 22, 56	NAME OF CEMETERY OR CREMATORY Elkton Cemetery	LOCATION (City, town, or county) (State) Elkton Md.
DATE REC'D BY LOCAL REG. 2-21-56	REGISTRAR'S SIGNATURE Mary B. Shue	24. FUNERAL DIRECTOR ADDRESS J.F.Eline & Son's Reisterstown, Md.	

BUREAU V. S.

FEB 23 1956

RECEIVED



VS. A15
MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1580

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01560

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 9. Film 93 2-27-56 et

1. PLACE OF DEATH COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Paradise Nursing Home		STREET ADDRESS (If rural, give location) 706 E. Arlington Ave.	
3. NAME OF DECEASED (Type or Print) Mary	(First)	(Middle) Agnes	(Last) Woods
4. DATE OF DEATH Feb. 20, 1956	(Month)	(Day)	(Year)
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Unknown Approx. 82 ? yrs.
9. AGE last birthday 82 Months ? Days ? Hours ? Min.		10. CITIZEN OF WHAT COUNTRY U.S.A	
11. BIRTHPLACE (State or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY U.S.A	
13. FATHER'S NAME ?? Woods		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY No. unknown	
17. INFORMANT AND ADDRESS James P. Walsh 806 Md. Trust Bldg.		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Myocardial failure		72 hrs
Antecedent cause(s) (b) Atherosclerotic CVD		Unknown
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

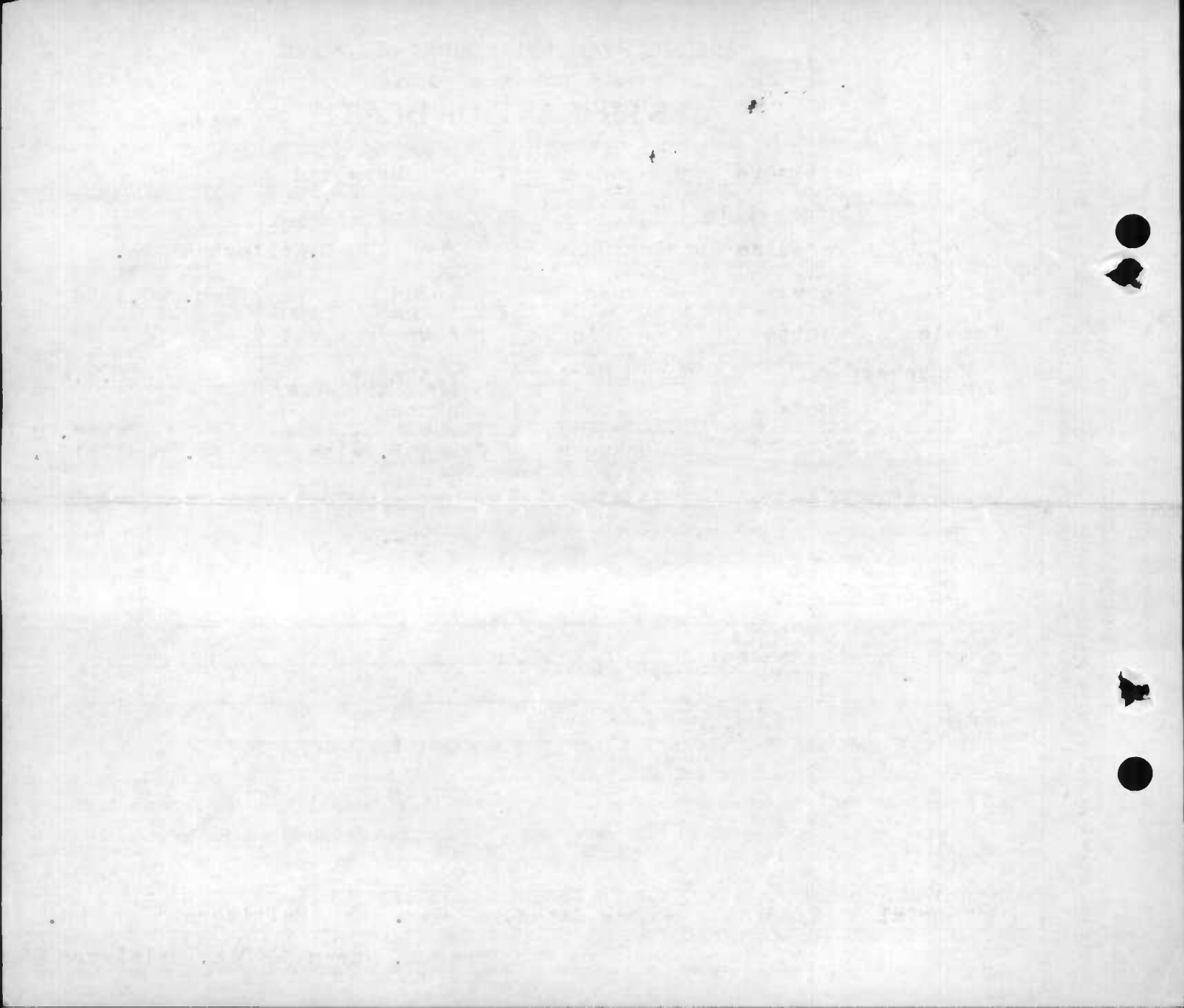
22. I hereby certify that I attended the deceased from **12-8**, 19**59**, to **2-20**, 19**56**, that I last saw the deceased alive on **2-19**, 19**56**, and that death occurred at **1:00 P** m., from the causes and on the date stated above.

SIGNATURE **Stephen M. Magness M.D. Catonsville 28, Md** ADDRESS **2-20-56** DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) **Burial** DATE THEREOF **2/23/56** NAME OF CEMETERY OR CREMATORY **New Cathedral Cem.** LOCATION (City, town, or county) **Baltimore** (State) **Md.**

DATE REC'D BY LOCAL REG. **Feb 23 1956** REGISTRAR'S SIGNATURE **G. W. Hedrick** 24. FUNERAL DIRECTOR **John A. Moran 3000 E. Baltimore St** ADDRESS

F. H. Lewis



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01561

Items 8,9 Filed 1922-11-56 et

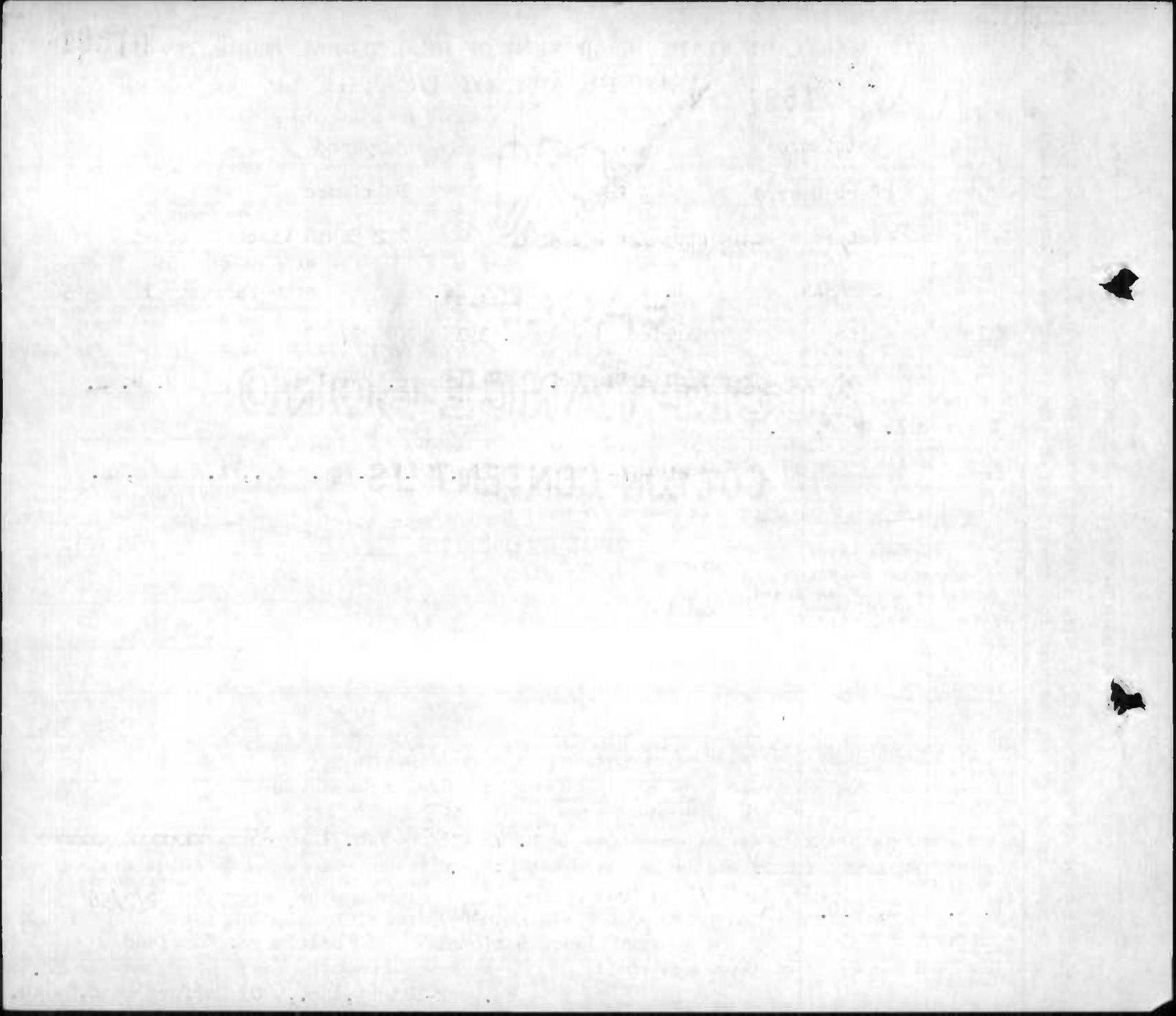
1581

CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN Fort Howard		5 Days		TOWN Baltimore		3V01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location) 222 South Vincent Street			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
SHERMAN L. WOOD, JR.				February 1 1956			
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH: July 8, 1918 1919	
9. AGE last birthday: 37		10. MONTHS: 36		11. YEARS: 36		12. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tool&die Maker Tool & Die Co.				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland	
13. FATHER'S NAME: Sherman L. Wood, Sr.				14. MOTHER'S MAIDEN NAME: Emma Deming			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW II				16. SOCIAL SECURITY NO. 219-07-4592		17. INFORMANT & ADDRESS: Clin.Rec.Vet.Adm.Hosp., Ft. Howard, Md.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						10 DAYS	
IMMEDIATE CAUSE (A) VIRAL ENCEPHALITIS							
DUE TO							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 2				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 27, 1956 to Feb. 1, 1956 and on Feb. 1, 1956 pronounced him dead, and that death occurred at 4:30 P.M. , from the causes and on the date stated above.							
SIGNATURE D. D. MARK, M.D.				ADDRESS FORT HOWARD, MARYLAND		DATE SIGNED 2/2/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 2-6-56		NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS Md. Wm. Cook-Blight, Inc., 6009 Harford Road, Balto.	



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the words "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1582 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01562

Items 11, 12, 13, 14, 15 Film G193 3-9-56 et

Reg. Dist. No.

44

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> <u>Ore Mar Steamship</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Point Ore Dock</u>		c. LENGTH OF STAY IN lb <u>20 hrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>60</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> <u>3401-4</u>	
f. STREET ADDRESS <u>1216 E. Baltimore St.</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>WORMAN X</u> First <u>Jacob</u> Middle <u></u> Last <u>Wornanen</u>		4. DATE OF DEATH <u>2-29-56</u> Month <u>29</u> Day <u>2</u> Year <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-26-92</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seaman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steamship</u>	
11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>216-12-8837</u>	
17. INFORMANT <u>Records of ore steamship co.</u>		Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. <u>NONE</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>	
20c. TIME OF INJURY Hour <u></u> o. m. <u></u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>M B Davis</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <u>M. B. Davis, M.D.</u>		DATE SIGNED <u>Feb 29-56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 2/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Moreland Mem.</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Philip Herung Sone</u>		24a. REC'D BY REGISTRAR <u>2024</u> 24b. REGISTRAR'S SIGNATURE <u>Lawson L. Larkins</u>	

MEDICAL CERTIFICATION

RECEIVED

MAR 2 1956

BUREAU V. S.

ED

V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

01563

1583

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH COUNTY <u>Baltimore Co</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Pikesville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>7 Sudbrook Court</u>	
3. NAME OF DECEASED (Type or Print) <u>Margaret</u>	(First) (Middle) (Last) <u>Wurzbarger</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>Feb 29 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>Apr 1, 1873</u>
9. AGE last birthday <u>82</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Pa.</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Clarence Dias</u>		14. MOTHER'S MAIDEN NAME <u>Lucietia Abraham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Stanley L. Wurzbarger</u>		<u>7 Sudbrook Crt. Pikesville, Md</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>BRONCHO PNEUMONIA, ACUTE</u>		<u>4 days</u>
Antecedent cause(s) (b) <u>CEREBRAL THROMBOSIS</u>		<u>3 months</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>ARTERIOSCLEROTIC HEART DISEASE & HYPERTENSION</u>		<u>5 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>Nov 18, 1955</u> , to <u>Feb 29, 1956</u> , that I last saw the deceased alive on <u>Feb 29, 1956</u> , and that death occurred at <u>11:20 A.M.</u> , from the causes and on the date stated above.		
SIGNATURE (Degree or title) <u>Donald H. Anthony M.D.</u>		ADDRESS <u>5329 Reisterstown Rd Baltimore, Md</u>
DATE SIGNED <u>March 1, 1956</u>		
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>3-2-56</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore Hebrew Cem</u>
LOCATION (City, town, or county) <u>Baltimore, Md.</u>		(State)
DATE REC'D BY LOCAL REG. <u>Mar 2, 1956</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>David R. Martin</u>
ADDRESS <u>1902 Eutaw Place</u>		

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2047



1584

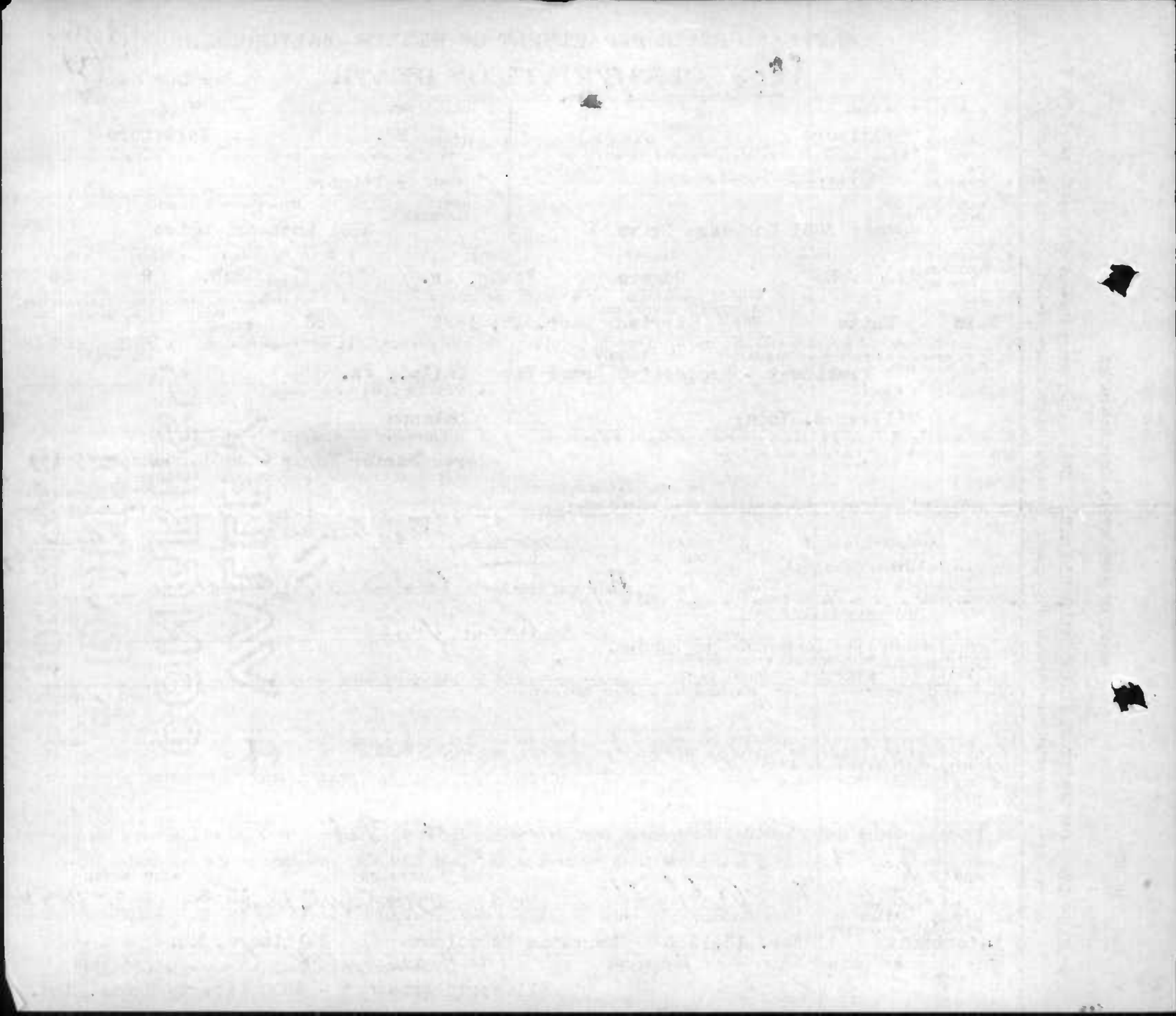
CERTIFICATE OF DEATH

Reg. Dist. No. 31

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Md.	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) Baltimore	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3801 Locheam Drive		STREET ADDRESS (If rural give location) 3801 Locheam Drive	
3. NAME OF DECEASED: (First) John (Middle) Odgers (Last) Young, Sr.		4. DATE (Month) (Day) (Year) OF DEATH: Feb. 9 1956	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: Apr. 18, 1892
9. AGE last birthday 63 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): President - Progressive Brass Die		10B. KIND OF BUSINESS OR INDUSTRY: Phila., Pa.	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: William H. Young		14. MOTHER'S MAIDEN NAME: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: Sarah Warner Young - 3801 Locheam Drive			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Coronary Occlusion			2 hrs
ANTECEDENT CAUSE (B) Myocardial Infarction			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. Coronary & Liver			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) (Minute) (Second) M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from Jan , 1956 to Feb , 1956 that I last saw the deceased alive on Feb 7 , 1956, and that death occurred at 6:25 PM , from the causes and on the date stated above.			
SIGNATURE Thos J. R. Hunt		DATE SIGNED 2-11-56	
ADDRESS 4509 Liberty Heights Ave.		M. D. 2-11-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		DATE THEREOF Feb. 13, 1956	
NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		LOCATION (City, town, or county) (State) Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR 2-13-56		REGISTRAR'S SIGNATURE Ellsworth Armacost	
24. FUNERAL DIRECTOR Ellsworth Armacost		ADDRESS 4600 Liberty Hgts. Ave.	

MARGIN RESERVED FOR BINDING



CERTIFICATE OF DEATH

Items 9, 13, 14 Film GI 93 3-9-56 et

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Md	CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore City
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Rural: Towson	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore City	STREET ADDRESS (If rural give location) 219 W. Mulberry St.
3. NAME OF DECEASED: (Type or Print) First: Tom Middle: Last: Yuem		4. DATE OF DEATH: (Month) (Day) (Year) 2 27 1956	
5. SEX: m.	6. COLOR OR RACE: yellow	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: 9/9/1880
9. AGE last birthday: 75 yrs.		10. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired. Kitchen Helper Restaurant	
11. BIRTHPLACE (State or foreign country): China		12. CITIZEN OF WHAT COUNTRY? China	
13. FATHER'S NAME: Unknown		14. MOTHER'S MAIDEN NAME: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH Immediate cause Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last.	(a) Cardiac decompensation DUE TO (b) Pulmonary tuberculosis DUE TO (c)	Interval Between Onset And Death 3 mos. (7?)
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11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
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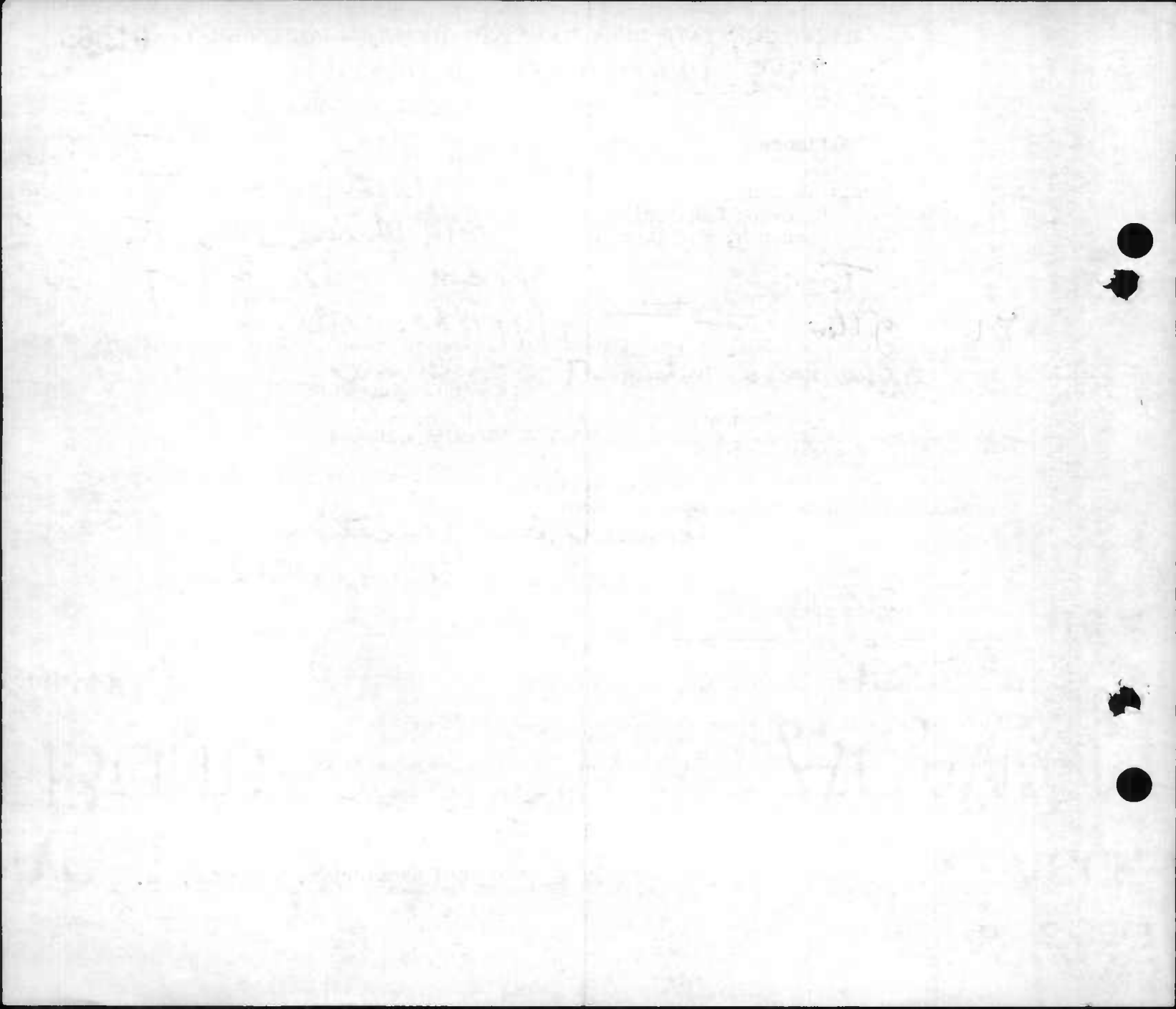
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 2/27, 1956, to 2/27, 1956, that I last saw the deceased alive on 2/27, 1956, and that death occurred at 5:20 PM, from the causes and on the date stated above.

SIGNATURE Melvin B. Fess	DATE THEREOF Feb 28/56	NAME OF CEMETERY OR CREMATORY Eudowood Sanatorium, Towson 4, Md.	LOCATION (City, town, or county) (State) Baltimore
DATE RECD BY LOCAL REGISTRAR Feb 28-56	REGISTRAR'S SIGNATURE Dec Nedrick	24. FUNERAL DIRECTOR Clarence M. Menn	ADDRESS 108 W. ...

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1586

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01566
Reg. Dist.

No. 45

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 107 Kingston Road		STREET ADDRESS (If rural, give location) 107 Kingston Road	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) Debra	(Middle) (DEBORAH)	(Last) Zeigler	(Month) 2 (Day) 19 (Year) 19 56
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: Oct 10 - 1954
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Infant		10b. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday: yrs. 16
13. FATHER'S NAME: George L. Zeigler		14. MOTHER'S MAIDEN NAME: Mildred Morgan	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: Parents above	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) Suppurative Otitis Media, Left. DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE Paul F. Men		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> 2/20/56	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial	DATE THEREOF Feb. 22 - 56	NAME OF CEMETERY OR CREMATORY Cedar Hill	LOCATION (City, town, or county) (State) Baltimore, Maryland H.A. Co. Md
DATE REC'D BY LOCAL REG. 2/20/56	REGISTRAR'S SIGNATURE Garth Hurley	24. FUNERAL DIRECTOR John D. Connolly	ADDRESS Essex

BUREAU V. S.

FEB 29 1956

RECEIVED